Prescribed medication administration chart

Phone: 1300 734 224 Fax: 1300 734 221
Email: intake@remedyhealthcare.com.au

Remedy HEALTHCARE

Patient details/label

Surname:
Given names:
DOB: Sex: ❒ M ❒ F
Address:

State: Postcode:
Phone number:

Hospital Doctor maintaining Clinical Governance post discharge:
Name:

Phone: **Pager:**

Signature:

GP details:
Name:

Phone:

Allergies and adverse drug reactions ❒ Nil known ❒ Known
(Complete details below for known)

Medicine (or other allergen)	Reaction/date	Sign

Medication chart number …… **of** ……

Hospital: ……
Ward/Unit: ……
Phone: ……**Fax:** ……

IV ACCESS DETAILS: ❒ PICC ❒ Cannula ❒ Hickman's **Date inserted:** **Date of last dressing:**
PICC length (cm): **Arm circumference (cm) on d/c:**
Date of first hospital dose of IV antibiotics: **First does of IV antibiotics administered in hospital without adverse event (tick):** ❒ Yes ❒ No
Please tick requested infuser device: ❒ Baxter infuser ❒ Sapphire Pump.
Ensure dose frequency indicates: 24 hour infusion/ Short Infusion (specify time required) /IV Push

Date:		**Dose**	**Date given**																				
Medicine (print generic name)			**Time given**																				
			Nurse Signature																				
Start Date:	**Cease Date:**	**Route**	**Date given**																				
			Time given																				
Doctors Name: **Doctors Signature:**		**Frequency**	**Nurse Signature**																				
Date:		**Dose**	**Date given**																				
Medicine (print generic name)			**Time given**																				
			Nurse Signature																				
Start Date:	**Cease Date:**	**Route**	**Date given**																				
			Time given																				
Doctors Name: **Doctors Signature:**		**Frequency**	**Nurse Signature**																				

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Telephone Orders (Nurses to document Doctors full name and contact details for all phone orders)

Date ordered	Medicine (print generic name)	Route	Dose	Frequency	Doctors name	Doctors Ph. Number	Date given	Time given	Nurse Signature (initials)

Medication chart number ..... of .....

Normal saline flush standing order: Doctor must sign for all IV medication orders to allow community nurse to administer IV push/flush.

Date:		Dose	Date given																			
Medicine : (Normal Saline) 0.9% Sodium Chloride for injection			Time given																			
			Nurse Signature																			
Start Date:	Cease Date:	Route	Date given																			
			Time given																			
Doctors Name: Doctors Signature:		Frequency	Nurse Signature																			

Anaphylaxis Management Guideline: All doses are recommended Adult Dosage

Medicine (generic name)	Dose Guidelines	Frequency	Route	Doctor to Sign
1. **ADRENALINE 1:1000**	0.3 – 0.5MG	PRN	IM	
Date:	Dr Name			Signature

Patient LOCAL pharmacy details
To facilitate Baxter

Name of Pharmacy:

Address:

Contact Person:

Phone:

Fax:

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Remedy HEALTHCARE

Patient details/label

Surname:
Given names:
DOB: Sex: ❒ M ❒ F
Address:

State: Postcode:
Phone number:

8 Rights of Medication Administration

1. Right Client
2. Right Dose
3. Right Route
4. Right Reason
5. Right Drug
6. Right Time
7. Right Documentation
8. Right Response

Medication chart number ..... of .....

Date:		**Dose**	**Date given**																			
Medicine (print generic name)			**Time given**																			
			Nurse Signature																			
Start Date:	**Cease Date:**	**Route**	**Date given**																			
			Time given																			
Doctors Name: **Doctors Signature:**		**Frequency**	**Nurse Signature**																			
Date:		**Dose**	**Date given**																			
Medicine (print generic name)			**Time given**																			
			Nurse Signature																			
Start Date:	**Cease Date:**	**Route**	**Date given**																			
			Time given																			
Doctors Name: **Doctors Signature:**		**Frequency**	**Nurse Signature**																			