Prescribed medication administration chart

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

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 : (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																					

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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 (print generic name)			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	
2.				
Date:	Dr Name			Signature

Patient LOCAL pharmacy details To facilitate Baxter
Name of Pharmacy:
Address:
Contact Person:
Phone:
Fax:

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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**																					