Prescribed Medication Administration Chart

Phone: 1300 734 224 Fax: 1300 734 221
Email: getbetter@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:

Authority to remove PICC Line (if known at time of referral):
Date of PICC line removal:
Name:
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
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																			
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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Medication chart number .....of .....

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

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