2

DRUG PRESCRIPTION AND ADMINISTRATION RECORD

WARD: _____

(Stick patient's printed label here)

CHART NO: _____

SURNAME: _____

FIRST NAME: _____

DATE OF BIRTH: _____ AGE: _____

CONSULTANT: _____

INTERN (Bleep Number): _____

DATE OF ADMISSION: _____

DIET: _____

KARDEX NO.: _____

WEIGHT (If Applicable): _____

DATE: _____

REVIEW DATE: _____ Dr. _____

ADDITIONAL PRESCRIPTIONS (Please tick)	Steroids	Warfarin	T.P.N.	Chemo	Sliding Scale

DRUG ALLERGIES (and manifestation of same)

FOR THE SAFETY OF THE PATIENT

GENERAL

1. Ensure that all patient details are entered above.
2. 24 hour clock must be used when charting and recording medications.

DOCTOR

1. Has a drug allergy history been taken? Signature: _____
2. Use approved names, BLOCK LETTERS, metric doses. English instructions. Avoid abbreviations.
3. Any changes in drug therapy must be ordered by a new prescription.
4. Discontinue a drug by drawing a line through it and a similar line through subsequent recording panels and sign.
5. Only one chart should be in use at any one time. When the chart is full, all current prescriptions should be entered on a new chart and the old one filed in the patient's notes.
6. Enter instructions for holding drugs on Page 2.

NURSES

1. Check the entries in every section to avoid omissions.
2. Administering Registered Nurse initials in appropriate box.
3. In the event of non-administration of a drug either
   - 3.1 enter X in the appropriate box and enter details on page 12 OR
   - 3.2 if the patient has refused a drug, enter R in the appropriate box OR
   - 3.3 if the patient has been fasting, enter F in the appropriate box.
4. Check that the drug has not already been administered.
5. When dose changes are prescribed please specify dose actually administered along with initials.

			SURGERY UNLESS SPECIFICALLY STATED OTHERWISE, TOGETHER WITH PRE-MED	
DATE	DRUG	VALID PERIOD	REASON	DOCTOR

ONCE ONLY DRUG & FIRST DOSE MEDICATION

DATE	TIME	DRUG	ROUTE	DOSE	SIGNATURE	GIVEN BY	PHARMACY

REGULAR PRESCRIPTIONS

DATE AND MONTH:

GIVEN BY:

INDICATE TIMES:

DRUG (Approved Name)

FREQUENCY

Dose	Route	Start Date	Valid Period

Signature

Stop Date Sign:

Pharmacy

REGULAR PRESCRIPTIONS

DATE AND MONTH:

GIVEN BY:

INDICATE TIMES:

DRUG (Approved Name)

FREQUENCY

Dose	Route	Start Date	Valid Period

Signature

Stop Date Sign:

Pharmacy

DRUG (Approved Name)

FREQUENCY

Dose	Route	Start Date	Valid Period

Signature

Stop Date Sign:

Pharmacy

DRUG (Approved Name)

FREQUENCY

Dose	Route	Start Date	Valid Period

Signature

Stop Date Sign:

Pharmacy

DRUG (Approved Name)

FREQUENCY

Dose	Route	Start Date	Valid Period

Signature

Stop Date Sign:

Pharmacy

DRUG (Approved Name)

FREQUENCY

Dose	Route	Start Date	Valid Period

Signature

Stop Date Sign:

Pharmacy

DRUG (Approved Name)				Date	
Dose	Max. Freq.	Route	Start Date	Time	
Signature		Valid Period	Stop Date	Dose Route	
Pharmacy				Dose Given	
				Given by	
DRUG (Approved Name)				Date	
Dose	Max. Freq.	Route	Start Date	Time	
Signature		Valid Period	Stop Date	Dose Route	
Pharmacy				Dose Given	
				Given by	
DRUG (Approved Name)				Date	
Dose	Max. Freq.	Route	Start Date	Time	
Signature		Valid Period	Stop Date	Dose Route	
Pharmacy				Dose Given	
				Given by	
DRUG (Approved Name)				Date	
Dose	Max. Freq.	Route	Start Date	Time	
Signature		Valid Period	Stop Date	Dose Route	
Pharmacy				Dose Given	
				Given by	
DRUG (Approved Name)				Date	
Dose	Max. Freq.	Route	Start Date	Time	
Signature		Valid Period	Stop Date	Dose Route	
Pharmacy				Dose Given	
				Given by	

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PREMEDICATION

DATE	DRUG APPROVED NAME	DOSE	ROUTE	SPECIAL INSTRUCTIONS	DOCTOR	TIME	GIVEN			Rx
							DATE	TIME	INITIALS	

SURGICAL ANTIBIOTIC PROPHYLAXIS (Valid for 24 hours)

DATE	DRUG	DOSE	ROUTE	SIGNATURE		0600	1000	1200	1400	1800	2200

PCA INFUSION

DRUG MG/ML			Date												
Dose MG	Lockout Time Min	4 Hr. Max. MG	Time												
Signature	Start Date	Stop Date	Given by												
DRUG MG/ML			Date												
Dose MG	Lockout Time Min	4 Hr. Max. MG	Time												
Signature	Start Date	Stop Date	Given by												

DRUGS NOT ADMINISTERED

DATE	TIME	DRUG	SIGNATURE	REASON