Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Medication Record

M.P.A.R.

ADULT ACUTE

Forename:

Surname:

DOB:

Hospital No.:

Consultant:

Admission Date: ...../...../...../

Drug Chart No. .....

Other Medication Records In Use (Please Tick Or Affix Sticker)

Insulin	☐	Haemodialysis	☐	TPN	☐
Chemotherapy	☐	Syringe Driver	☐	Nutrition	☐
PCA	☐	Blood Products	☐		
Anticoagulants / Warfarin	☐	Other	☐		

.....

Weight			CrCl (Cockcroft Gault) mL/min		
Weight (Kg)	Date	Initials	Value	Date	Initials
Measured Height	Height	(cm)	Date:	Initials:	

Patient Conditions Affecting Oral Doses

Restricted oral route (e.g. swallowing problems) ☐

Enteral Feeding (e.g. NG tube, PEG feeding) ☐

Specify .....

Signature: ..... Date: .....

Oral Medication in Surgical Pre Operative Patients

Prescribed medication can be given up to 2 hours prior to surgery with a small drink of water (less than 30mL) except:

a. if there are specific directions to hold the medication,
b. if the patient is unable to swallow oral medication due to reasons other than fasting for surgery, or
c. if the drug is an oral hypoglycaemic agent, a diuretic, an ACE inhibitor or ARB, an anticoagulant (may require bridging), or as indicated in local guidelines

Allergies/Adverse Drug Reactions: Complete below before medication is administered.

OR **Tick if No Known Drug Allergy** ☐ Signature: Date:

Medication / Other	Nature of Reaction	Signature	Date

Index	Page
Cover	1
Signature Record & Communication section	2
Pre-admission medication and medication reconciliation	3
Once only & depots & variable dose	4
~~VTE prevention protocol~~	~~5~~
Regular	5 – 6
As required	7 ~~8~~
Antimicrobials	8 – 9 ~~9~~
Oxygen	10 ~~10~~
Fluids & electrolytes	11 ~~11~~

How to use this Medication Record

- Print clearly in un-joined letters. Use a black ballpoint pen
- Pharmacists may use a permanent green pen
- Complete Allergy Status before prescribing or administering medication
- Complete the signature record before writing in the Record
- Any medication prescribed on a separate document should also be written in the regular section with a reference to the separate document, e.g. Insulin, See Diabetes Chart
- To stop a prescription, draw a line through the prescription and a line at the end of the last filled in administration section. Enter the stop date, the reason for stopping and sign
- To change a prescription, stop it as above and write the new prescription. Do not alter existing prescriptions
- Prescribe by generic drug name, except in cases where the brand name must be specified, e.g. combination products, modified release products, controlled drugs, insulins, biological medications, anti-epileptics, immunosuppressants etc
- Check for entries in the Communication Section each time you use this Record

RCSI · FAM · RGN · AT

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Forename:
Surname:
DOB:
Hospital No.:
Consultant:

Codes for recording omitted doses	Actions to be taken
1. Patient absent from ward	Administer on patient's return
2. Medication not available	If already ordered, check with pharmacy. If not, order. Administer dose on receipt of drug.
3. Route not available, e.g fasting, vomiting, difficulty swallowing, no IV access	Document specific reason and inform team if appropriate.
4. Medication held due to patient condition	
5 Patient refused medication	
6. Other	

Medication Issues Communication Record

Use this section to document medication-related issues and actions.
In addition, communicate issues directly to the appropriate health professional.

Date	Time	Communicated medication issues / actions	Signature	Contact No

Signature Record

Each healthcare professional who writes in this chart MUST complete the signature record

Date	Name (Print)	Initials	Signature	Reg No	Contact No	Date	Name (Print)	Initials	Signature	Reg No	Contact No

2011

Forename:

Surname:

DOB:

Hospital No.:

Consultant:

Allergies / Adverse Drug Reactions

Medicine/Other	Nature of Reaction

Or No known allergies ☐

Signature: Date:

Pre-Admission Medication & Medication Reconciliation

Pre-Admission Medication List

Source *(tick all that apply)*: Patient/ Carer/ Relative ☐

GP Surgery ☐ Retail Pharmacy ☐ Care Facility ☐

Other ☐, specify .....

Source name(s): ..... Phone: .....

Completed by: .....

Contact no.:..... Date: .....

List Verification / Medication Reconciliation

Source *(tick all that apply)*: Patient/ Carer/ Relative ☐

GP Surgery ☐ Retail Pharmacy ☐ Care Facility ☐

Other ☐, specify .....

Source name(s): ..... Phone: .....

Completed by: .....

Contact no.:..... Date: .....

	Medication	Route	Dose	Frequency	Consistent with drug chart Rx?	Reason/ Action (e.g stopped, increased) with rationale	Discharge (tick)*
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							

*Prescribed and/or changes communicated on discharge prescription and discharge summary

Comments:

Forename:

Surname:

DOB:

Hospital No.:

Consultant:

Allergies / Adverse Drug Reactions

Medicine/Other	Nature of Reaction

Or No known allergies ☐

Signature: Date:

Once Only Medicines, Depots

Prescription							Administration		
Date	Drug (Generic Name)	Route	Dose	Special Instructions eg. Diluent & Volume	Time & Date to be given	Signature	Given by / Checked by	Date	Time given (24Hr Clock)

Variable Dose Prescriptions (Reducing dose Steroids, Chlordiazepoxide etc).

Drug (Generic Name)						Route	Special Instructions						Reviewed by / Date		
Date	Result	Dose	Frequency	Prescriber Sig	Reg No	Given By	Time	Given By	Time	Given By	Time	Given By	Time	Given By	Time
Stop Date		Reason			Signature	Continue at Discharge Yes ☐ No ☐ Initials									

Drug (Generic Name)						Route	Special Instructions						Reviewed by / Date		
Date	Result	Dose	Frequency	Prescriber Sig	Reg No	Given By	Time	Given By	Time	Given By	Time	Given By	Time	Given By	Time
Stop Date		Reason			Signature	Continue at Discharge Yes ☐ No ☐ Initials									

A DA 11

Forename:

Surname:

DOB:

Hospital No.:

Consultant:

Allergies / Adverse Drug Reactions

Medicine/Other	Nature of Reaction

Or No known allergies ☐

Signature:　　Date:

Regular Prescriptions

(Prescribe antimicrobials in antimicrobials section)

Year

Day & Month DD/MM

Prescriber circle time or enter variable time in second column

Drug (Generic Name)

Route | Dose | Frequency & Prescriber circle time

Special Instructions | Reviewed By | Date

Prescriber Sig | Reg No | Date

Stop Date | Reason | Signature

6								
8								
10								
12								
14								
18								
22								

Drug (Generic Name)

Route | Dose | Frequency & Prescriber circle time

Special Instructions | Reviewed By | Date

Prescriber Sig | Reg No | Date

Stop Date | Reason | Signature

6								
8								
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12								
14								
18								
22								

Drug (Generic Name)

Route | Dose | Frequency & Prescriber circle time

Special Instructions | Reviewed By | Date

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Drug (Generic Name)

Route | Dose | Frequency & Prescriber circle time

Special Instructions | Reviewed By | Date

Prescriber Sig | Reg No | Date

Stop Date | Reason | Signature

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Forename:

Surname:

DOB:

Hospital No.:

Consultant:

Allergies / Adverse Drug Reactions

Medicine/Other	Nature of Reaction

Or No known allergies ☐

Signature: Date:

Regular Prescriptions

(Prescribe antimicrobials in antimicrobials section)

Year

Day & Month DD/MM

Prescriber circle time or enter variable time in second column

Drug (Generic Name)

Route | Dose | Frequency & Prescriber circle time

Special Instructions | Reviewed By | Date

Prescriber Sig | Reg No | Date

Stop Date | Reason | Signature

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Route | Dose | Frequency & Prescriber circle time

Special Instructions | Reviewed By | Date

Prescriber Sig | Reg No | Date

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Stop Date | Reason | Signature

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22								

6 8 11

Forename:

Surname:

DOB:

Hospital No.:

Consultant:

Allergies / Adverse Drug Reactions

Medicine/Other	Nature of Reaction

Or No known allergies ☐

Signature: Date:

As Required (PRN) Prescriptions

Year	Month	Date	Time Given	Route	Dose Given	Given By	Date	Time Given	Route	Dose Given	Given By

Drug (Generic Name)

Route | Dose | Max Frequency

Special Instructions

Prescriber Sig | Reg No | Date

Reviewed By | Date

Stop Date Reason Signature

Pre Admission Medication?

Yes ☐

No ☐

Continue at Discharge

Yes ☐

No ☐

Initials

Drug (Generic Name)

Route | Dose | Max Frequency

Special Instructions

Prescriber Sig | Reg No | Date

Reviewed By | Date

Stop Date Reason Signature

Pre Admission Medication?

Yes ☐

No ☐

Continue at Discharge

Yes ☐

No ☐

Initials

Drug (Generic Name)

Route | Dose | Max Frequency

Special Instructions

Prescriber Sig | Reg No | Date

Reviewed By | Date

Stop Date Reason Signature

Pre Admission Medication?

Yes ☐

No ☐

Continue at Discharge

Yes ☐

No ☐

Initials

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Forename:	
Surname:	
DOB:	
Hospital No.:	
Consultant:	

Allergies / Adverse Drug Reactions

Medicine/Other	Nature of Reaction

Or No known allergies ☐

Signature: Date:

Antimicrobial Prescriptions

This section is for short-course antimicrobials. Prescribe long-term antimicrobials (e.g. for PCP prophylaxis, post-splenectomy, TB treatment) in the Regular Prescriptions section.

Administered By / Witnessed By

Drug (Approved Name) | Date

Route | Dose | Frequency & Prescriber circle time

What infection are you treating? | Stop Date

Prescriber Sig | Reg No

Reviewed By / Date | Special Instructions

Day → | Date/Mth | 06 | 10 | 12 | 14 | 18 | 22

Review Ongoing Therapy

Antimicrobial prescribing decision at 24-48 hrs and document in chart:
1. Stop antibiotics if no infection
2. Assess for IV-PO switch as per local guidelines
3. Narrower spectrum if possible based on C&S (Or broader spectrum if indicated)
4. Continue and review in another 24 hours
5. Consider OPAT referral

Start Smart then focus; Antimicrobials should only be commenced where there is clear evidence of infection

Automatic stop unless rewritten

Drug (Approved Name) | Date

Route | Dose | Frequency & Prescriber circle time

What infection are you treating? | Stop Date

Prescriber Sig | Reg No

Reviewed By / Date | Special Instructions

Day → | Date/Mth | 06 | 10 | 12 | 14 | 18 | 22

Automatic stop unless rewritten

Drug (Approved Name) | Date

Route | Dose | Frequency & Prescriber circle time

What infection are you treating? | Stop Date

Prescriber Sig | Reg No

Reviewed By / Date | Special Instructions

Day → | Date/Mth | 06 | 10 | 12 | 14 | 18 | 22

Automatic stop unless rewritten

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Forename:

Surname:

DOB:

Hospital No.:

Consultant:

Allergies / Adverse Drug Reactions

Medicine/Other	Nature of Reaction

Or No known allergies ☐

Signature: Date:

Antimicrobial Prescriptions

This section is for short-course antimicrobials. Prescribe long-term antimicrobials (e.g. for PCP prophylaxis, post-splenectomy, TB treatment) in the Regular Prescriptions section.

Administered By / Witnessed By

Drug (Approved Name) | Date

Route | Dose | Frequency & Prescriber circle time

What infection are you treating? | Stop Date

Prescriber Sig | Reg No

Reviewed By / Date | Special Instructions

Day → | Date/Mth | 06 | 10 | 12 | 14 | 18 | 22

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4. Continue and review in another 24 hours
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Start Smart then focus;
Antimicrobials should only be commenced where there is clear evidence of infection

Automatic stop unless rewritten

Drug (Approved Name) | Date

Route | Dose | Frequency & Prescriber circle time

What infection are you treating? | Stop Date

Prescriber Sig | Reg No

Reviewed By / Date | Special Instructions

Day → | Date/Mth | 06 | 10 | 12 | 14 | 18 | 22

Automatic stop unless rewritten

Drug (Approved Name) | Date

Route | Dose | Frequency & Prescriber circle time

What infection are you treating? | Stop Date

Prescriber Sig | Reg No

Reviewed By / Date | Special Instructions

Day → | Date/Mth | 06 | 10 | 12 | 14 | 18 | 22

Automatic stop unless rewritten

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Forename:	
Surname:	
DOB:	
Hospital No.:	
Consultant:	

Allergies / Adverse Drug Reactions	
Medicine/Other	Nature of Reaction
Or No known allergies ☐	
Signature:	Date:

Oxygen Therapy

Prescriber: For most chronic conditions, oxygen should be prescribed to achieve a target saturation of 94-98% (or 88-92% for those at risk of hypercapnic respiratory failure ie. CO_2 retainers).

Is the patient a known CO_2 retainer ? ☐ Yes ☐ No **Prescriber tick here if to continue upon discharge ☐**

Prescription:	Administration: Check and record flow rate (FR)/device (D) at each medicine round or other times specified and sign. Record oxygen saturations in the patient's observation chart

Year: **Day and Month** → **Other Times** ↓																
Continuous oxygen therapy ☐ Or 'When required' oxygen therapy ☐	**6**															
	FR															
	D															
Target oxygen Saturation ☐ 88-92% ☐ 94-98% Other saturation range .... Tick here ☐ if saturation not indicated and state reason e.g. end of life care	**10**															
	FR															
	D															
	12															
	FR															
Starting device and flow rate:	D															
	14															
	FR															
Prescriber Sig Reg No	D															
Date	**18**															
Stop Date Reason Sig	FR															
	D															
	22															
Reviewed by Date	FR															
	D															

Year: **Day and Month** **Other Times** ↓																
Continuous oxygen therapy ☐ Or 'When required' oxygen therapy ☐	**6**															
	FR															
	D															
Target oxygen Saturation ☐ 88-92% ☐ 94-98% Other saturation range .... Tick here ☐ if saturation not indicated and state reason e.g. end of life care	**10**															
	FR															
	D															
	12															
	FR															
Starting device and flow rate:	D															
	14															
	FR															
Prescriber Sig Reg No	D															
Date	**18**															
Stop Date Reason Sig	FR															
	D															
	22															
Reviewed by Date	FR															
	D															

Device Codes

RA Room Air (not requiring O_2, weaning or on PRN O_2)	**CP** Patient on CPAP system	**V24** Venturi 24% (change figure as appropriate for % in use)
SM Simple mask	**NV** Patient on NIV System	**H28** Humidified oxygen at 28% (change figure as appropriate for percentage in use)
N Nasal Cannulae	**OTH** Other device (specify)................	
RM Reservoir mask		
TM Tracheostomy mask		

If a ward patient is requiring high flow oxygen via non rebreathe mask, consider medical review.
If target saturations are 88-92%, nebulised drugs should not be driven by oxygen (unless specified by the doctor).

Forename:	
Surname:	
DOB:	
Hospital No.:	
Consultant:	

Allergies / Adverse Drug Reactions	
Medicine/Other	Nature of Reaction
Or No known allergies ☐	
Signature:	Date:

Fluid +/- Electrolyte Infusions

Date	Fluid +/- Electrolyte and Dose	Volume	Route	Duration /Rate	Start Time	Prescriber Sig & Reg No	Prepared by / Given by	Checked by	Admin Rate	Time Started

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