

Medication Record MRAR





Forename:						Admission Date:/						
Surname:							Chart No.					
DOB:							Medication Records In Use (Please Tick Or Affix Sticker)					
Hospital No	.:					Insulin Chemo PCA	ı □ Haemodialysis □ TPN otherapy □ Syringe Driver □ Nutritic □ Blood Products □	on 🗆				
Consultant:						Anticoa / Warfa	agulants Other 🗆 arin 🗆					
	Weight		CrCl (C	ockcroft Gault)	ml /mi	n 1	D. N A O H					
Weight (Kg)	Date	Initials	Value Value	Date	Initials		Patient Conditions Affecting Oral Doses	Control of the Contro				
							Restricted oral route (e.g. swallowing problems)					
							Enteral Feeding (e.g. NG tube, PEG feeding)					
							Specify					
Measured He	ight Height	(cm)	Date:	Initials:		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 Rea	ctions: Complete below before medication is	administered.	and an annual state for the development of the constitution of supplements of the constitution of the confidence of the
OR Tick if No Known Drug Alle	ergy □ Signature:	Date:	
Medication / Other	Nature of Reaction	Signature	Date
,			
	2.		

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Pre-admission medication and medication reconciliation	on	3
Once only & depots & varia	ble dose	4
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Regular	5-	- 6
As required	7	Æ
Antimicrobials	8-9	2
Oxygen	10	32
Fluids & electrolytes	1/	28

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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

Forename:	Codes for recording omitted doses	Actions to be taken
Tolename.	1. Patient absent from ward	Administer on patient's return
Surname:	2. Medication not available	If already ordered, check with pharmacy. If not, order. Administer dose on receipt of drug.
DOB:	3. Route not available, e.g fasting, vomiting, difficulty swallowing, no IV access	. ,
Hospital No.:	4. Medication held due to patient condition	Document specific reason and inform team if appropriate.
Consultant:	5 Patient refused medication	team ii appropriate,
	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
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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
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Surname: DOB:			Aller	gies / Advers	se Drug Reacti	ons	
			Medi	cine/Other		Nature of Reaction	
DOD.			 				
Hogoital No.							
Hospital No.:			Or No	known aller	gies □		
Consultant:			1 1	ature:	g.00 L	Date:	
			J L				
Pre-Admission Medication & Medication	n Reco	nciliatio	n				
Pre-Admission Medication List			List V	erification /	Medication Re	conciliation	
Source (tick all that apply): Patient/ Carer/ Relative			Sourc	e (tick all that a	<i>apply)</i> : Patier	nt/ Carer/ Relative 🗆	
GP Surgery ☐ Retail Pharmacy ☐ Care Facility			GF	Surgery 🗆 🛭	Retail Pharmacy [□ Care Facility □	
Other , specify			Ot	her □, specify			
Source name(s): Pho			1			Phone:	
Completed by:							
Contact no.: Date:						Date:	
Medication	Route	Dose	Frequency	Consistent with drug chart Rx?	Reason/ Action (e. with rationale	g stopped, increased)	Discharge (tick)*
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					Medici	ine/Othe	er			Natu	re of R	eactio	n
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DOB:													
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DOB													
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Hos	oital No.:			Or No	know	n allergie							
Cons	sultant:			Signa		- unorgio			[Date:			
Regular Pres	criptions		Year			Day	& Month	DD/MM	ľ				
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Stop Date	Reason Signature												
					22								

Forename:

Allergies / Adverse Drug Reactions

	Fore	name:							Alle	rgies /	Advers	e Drug	Reacti	ions		
	Surn	ame:							Med	licine/0	ther			Natur	e of Re	action
	DOB:															
	Hosp	ital No.:														
	Cons	ultant:						- 1		o know	n allerç	jies □				
								L	Sign	ature:	· ·			D	ate:	
As Requ	ired ((PRN) Pres	criptions													
Year			Month		Date	Time Given	Route	D Gi	ose iven	Given By	Date	Time Given	Route	Dose Given	Given By	
Drug (Generic	c Name)	91-10-10-1														
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																No □
Special Instru	uctions ·															Continue
																at Discharge
Prescriber Sig	g		Reg No	Date												1
																Yes 🗆
Reviewed By			L	Date	Stop D	ate	Reas	on		Sig	nature	L	L		L	No □ Initials
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Drug (Generic	c Name)		-0		 			Г					1			
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Route	I	Dose	Max Frequency		-											Admission Medication?
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Special Instru	untions															No □
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				7												Discharge
Prescriber Sig	g		Reg No	Date												Yes □
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Reviewed By				Date	Stop D	ate	Reas	on		Sig	nature					Initials
Drug (Generic	c Name)			2-7//2-11-11-11-11												
																Pre Admission
Route	[Oose	Max Frequency													Medication?
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Special Instru	uctions	476-20		.co.rwynk	-											No □
					-											Continue at
Prescriber Sig	α		Reg No	Date	-			-								Discharge
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Reviewed By				Date	Stop D	alt	Reas	nu		519	nature					Initials
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Forename:									se Drug Read	tions				
Surname:		8				Me	dicine/Ot	her		Na	ture of	Reacti	on	
DOB:						-				-				
						-				-				
Hospital No.:						Or I	No know	aller	nies 🗆					
Consultant:						1	nature:	ι αποιξ	gics 🗆		Date:			
Antimicro	bial P	rescript	tions			L				-				
This section is fo	or short-	course antin	nicrobials, Pres	cribe long-term antimic atment) in the Regular P	robials rescriptions	section		Adn	ninistered By	/ Wit	nesse	d By		
Drug (Approved	Name)			Date	Day				Review			Ť	T	T
					Date	e/Mth			Ongoing Therapy				-	1
Route	Dose		Frequency 8	Prescriber circle time	06				Петару		+			1 _
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	Criber Sig Doo No.			14				ocal g				+	rtom less	
rescriber Sig	criber Sig Reg No		Reg No	18				s per l				+	F A	
Reviewed By		Special Ir	structions		22				hart: itch as if indi					1
Date				a.					o sw Strum refer				1	1
Drug (Approved	Name)			Date	Day	→	\top	T	bing decision at 24-48 hrs and document in chart: infection 2. Assess for IV-P0 switch as per local guidelines f possible based on C&S (for broader spectrum if indicated) in another 24 hours 5. Consider OPAT referral		\forall			
	T				Date/	/Mth			and de ssess broad broad onside		\top			
Route	Dose		Frequency &	Prescriber circle time	06				2. A 2. A 8.S (0r 5. C	1				
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What infection ar	e you tre	eating?		Stop Date	12				sion a basec r 24 h					Automatic stop unless rewritten
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Reviewed By		Special In:	structions		22				presc ics if r sctrum					
Date									obial ntibiot rer spe se and				,	
Orug (Approved N	lame)			Date	Day -	→			Antimicrobial prescribi 1. Stop antibiotics if no in 3. Narrower spectrum if 4. Continue and review in	T		1	İ	
					Date/	Mth			4.0.4 4.0.0	+				
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Forename:					Allergies / Adverse Drug Reactions											
						Medicine/Other Nature of Reaction						n				
Surname:																
DOB:																
Hospital No.:																
Consultant:								known all	lergies							
						Signatu	ıre:				Da	te:				
Antimicrot This section is fo	r short-co	ourse antim	icrobials, Presci	ribe lo	ng-term antimicrot	oials		٨	dminic	stored D	. / 14/		d D			
Drug (Approved	Name)	oost-spiene	ctomy, TB treat	ment)	in the Regular Pres			A		tered B	y / w	itnes	sea B	У	_	
					Date	Day	, →			Review ngoing						
Route	Dose		T				Date/Mth			herapy						
riodic	Dose		Frequency &	Prescriber circle time		06										
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David 18				22		+		h as indic		-	-	-		-		
Reviewed By Date		Special In	structions			-22		-		switc ım if ferra		-	_	-		
Drug (Approved	Mamo)				In.	+			i	V-PO pectri						
Drug (Approved Name) Date				Day	\rightarrow			for I								
				Date/Mth			and	ssess broa onsic								
Route Dose Frequency & Preso		rescri	escriber circle time				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						_			
					10			24-4	on C2						stop	
What infection are you treating?			Stop Date	12			on at	ased 24 ho						Automatic stop unless rewritten		
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Drug (Approved N	vame)				Date	Day	\rightarrow		timic	Stop						
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Prescriber Sig				Regi	No	14		+-+	j	Antimicrobials should only be commenced where there is clear evidence of infection						Automatic stop unless rewritten
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Reviewed By		Special Ins	tructions			22				micro ere th						
Date									Anti							

Forename:		Allergies / Adverse Drug Reactions												
Tolename.		M	Medicine/Other Nature of Reaction								ı			
Surname:													M. T. C.	garantee Coliffrance
DOB:														
Hospital No.:														
Consultant:			Or No known allergies □ Signature: Date:											
Oxygen Therapy				and Accombine and Other Entertainment	Comment of the section of	tera sec esta de talencia de caracteria de la caracteria de la caracteria de la caracteria de la caracteria de			unatestalende unterstütten		100.00.00 (March	B. W. B. W. B.	10 00000000000000000000000000000000000	Material
Prescriber: For most chronic conditions, c					-		tion of	f 94-	98%					
Is the patient a known CO2 retainer							onti	nue	upo	n dis	cha	ırge	: П	
Prescription:		or	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 Other Tin	Month ————— nes —————	→												
Continuous oxygen therapy	6	*							Management of the last	CONTRACTOR CONTRACTOR	ROPHING COLLEGE BOOK	tricovition in the		
Or 'When required' oxygen therapy	FR D							=	-	+				
Target oxygen Saturation ☐ 88-92% ☐ 9	1.5													
Other saturation range	FR D				1						+	_		
e.g. end of life care	12													
Starting device and flow rate:	FR D		+		+-	+					+	\dashv	\dashv	
	14													
Drongribor Cir.	FR										4			
Prescriber Sig Reg No Date	D 18	_			+				-					
Stop Date Reason Sig	FR													
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Reviewed by Date	FR	_	+		+	+		-						
	D													
Year: Day and	Month								Т		T		T	
Other Tin	ies ———	7												
Continuous oxygen therapy	6												EMBAROL MANAGEM	up sur phan
Or 'When required' oxygen therapy	FR D	_	+			+		+	-	\rightarrow	-			
Target oxygen Saturation ☐ 88-92% ☐ 9	94-98% 10										士			
Other saturation range	FR D		\vdash	_		-			_	+	+		-	
Tick here □ if saturation not indicated and state reason e.g. end of life care	12								\dashv	_	_			
Starting device and flow rate:	FR													
Total mig do not did not read	D 14	_			+			-	\dashv	\dashv	_		-	
	FR										\perp			
Prescriber Sig Reg No	D										\bot			
Date	18 FR					-	-	-	-		+	-	-	
Stop Date Reason Sig	D		\Box					_		_	\top	_		
Reviewed by Date	22													
neviewed by Date	FR D				-					-	-	-		
Device Codes														
RA Room Air (not requiring 02, weaning or on PRN 02)	CP Patient on CPAP syst		7718 0 07 2	V24 Venturi 24% (change figure as ap								ı use)		
SM Simple mask NV Patient on NIV System N Nasal Cannulae OTH Other device										8% (cha		gure a	S	
RM Reservoir mask	(specify)					d	phiohlig	ισ 101 β	ioi Gel Illa	age in u	JC)			
TM Tracheostomy mask	37													
If a ward patient is requiring high flow oxygen via non rebre If target saturations are 88-92%, nebulised drugs should no				e doctor).									Employed at the great on	
	10 8	//		//										
	10 0	//												

Forename:	Allergies / Adverse Drug Reactions							
Toroname.	Medicine/Other	Nature of Reaction						
Surname:								
DOB:								
Hospital No.:								
Consultant:	Or No known allergies □							
Consultant.	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
										-
	THE PROPERTY OF THE PARTY OF TH									
				-						