Attach ADR sticker | **Diabetic on insulin**

Affix patient identification label here

URN:

Family name:

Given names:

Address:

Not a valid prescription unless identifiers present

Date of birth: **Sex:** M ☐ F ☐

Allergies and adverse drug reactions (ADR)

☐ **Nil known** ☐ **Unknown** (tick appropriate box or complete details below)

Medicine (or other)	Reaction / type / date	Initials

Sign ..... Print ..... Date .....

Medication chart _____ of _____

Weight (kg) _____ Height (cm) _____

IV fluid administration

Date	No	Type of fluid (including strength)	Amount	Time	Additions to flask	Prescriber's signature	Administration				
							Start date	Start time	Finished time	Total infused	RN signature

Once only and nurse initiated medicines and pre-medications

Date prescribed	Medicine (print generic name)	Route	**Dose**	Date / time of dose	Prescriber / Nurse Initiator (NI)		Given by	Time given
					Signature	Print name		

Telephone orders (to be signed within 24 hours of order)

Date / time	Medicine (print generic name)	Route	**Dose**	Frequency	Check initials		Prescriber name	Prescriber signature	Date	Record of administration
					N1	N2				Time / given by

VTE risk assessed: Yes ☐ Prophylaxis not required ☐ Contraindicated ☐ Signature: Date:

Medicines taken prior to presentation to hospital
(Prescriber, over the counter, complementary) Own medicines brought in? ☐ Y ☐ N Administration aid (specify) .....

Medicine	Dose and frequency	Duration	Medicine	Dose and frequency	Duration

GP: **Community pharmacy:**

Sign: Print: Date: Medicines usually administered by:

Affix patient identification label here

URN:

Family name:

Given names:

Address:

Not a valid prescription unless identifiers present

Date of birth: **Sex:** M ☐ F ☐

First prescriber to print patient name and check label correct: .....

Attach ADR sticker

See front page for details

As required PRN medicines

Year: 20.....

Date	Medicine (print generic name)			Date														Continue on discharge? Yes / No	Date:
Route	Dose Hourly frequency **PRN**	Max PRN dose/24 hrs		Time														Dispense? Yes / No	
Indication	Pharmacy			Dose														Duration: ..... days Qty:	
Prescriber signature	Print your name	Contact		Route															
				Sign															
Date	Medicine (print generic name)			Date														Continue on discharge? Yes / No	Pharmacist:
Route	Dose Hourly frequency **PRN**	Max PRN dose/24 hrs		Time														Dispense? Yes / No	
Indication	Pharmacy			Dose														Duration: ..... days Qty:	
Prescriber signature	Print your name	Contact		Route															
				Sign															
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Route	Dose Hourly frequency **PRN**	Max PRN dose/24 hrs		Time														Dispense? Yes / No	
Indication	Pharmacy			Dose														Duration: ..... days Qty:	
Prescriber signature	Print your name	Contact		Route															
				Sign															
Date	Medicine (print generic name)			Date														Continue on discharge? Yes / No	Print your name:
Route	Dose Hourly frequency **PRN**	Max PRN dose/24 hrs		Time														Dispense? Yes / No	
Indication	Pharmacy			Dose														Duration: ..... days Qty:	
Prescriber signature	Print your name	Contact		Route															
				Sign															
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Prescriber signature	Print your name	Contact		Route															
				Sign															
Date	Medicine (print generic name)			Date														Continue on discharge? Yes / No	Prescriber's signature:
Route	Dose Hourly frequency **PRN**	Max PRN dose/24 hrs		Time														Dispense? Yes / No	
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				Sign															
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				Sign															
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				Sign															
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Indication	Pharmacy			Dose														Duration: ..... days Qty:	
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				Sign															