AFFIX PATIENT IDENTIFICATION LABEL HERE AND OVERLEAF

ALLERGIES & ADVERSE DRUG REACTIONS (ADR) (tick appropriate box or fill in details below) ☐ NIL ☐ UNKNOWN ☐ KNOWN		
Drug (or other)	Reaction/Type/Date	Initials
Sign .... Print .... Date		

Family Name:

Given Names: NOT A VALID PRESCRIPTION

Address: UNLESS IDENTIFIERS PRESENT

Date of Birth: Sex: ☐M ☐F

First Prescriber **to print patient name and check label correct:**

Weight (kg): ......

Date weighed: ....

VERY SPECIAL kids

REGULAR MEDICATIONS

YEAR 20.............. DATE & MONTH

PRESCRIBER MUST ENTER administration times

Date	Medicine & Strength (Print Generic Name)										
Route	Dose	Frequency & NOW enter times									
Pharmacy/Additional Information											
Prescriber Signature		Print Your Name									
Date	Medicine & Strength (Print Generic Name)										
Route	Dose	Frequency & NOW enter times									
Pharmacy/Additional Information											
Prescriber Signature		Print Your Name									
Date	Medicine & Strength (Print Generic Name)										
Route	Dose	Frequency & NOW enter times									
Pharmacy/Additional Information											
Prescriber Signature		Print Your Name									
Date	Medicine & Strength (Print Generic Name)										
Route	Dose	Frequency & NOW enter times									
Pharmacy/Additional Information											
Prescriber Signature		Print Your Name									
Date	Medicine & Strength (Print Generic Name)										
Route	Dose	Frequency & NOW enter times									
Pharmacy/Additional Information											
Prescriber Signature		Print Your Name									
Date	Medicine & Strength (Print Generic Name)										
Route	Dose	Frequency & NOW enter times									
Pharmacy/Additional Information											
Prescriber Signature		Print Your Name									

DO NOT WRITE IN THIS BINDING MARGIN

NOT A VALID ORDER UNLESS LEGIBLE

RECOMMENDED ADMINISTRATION TIMES
GUIDELINES ONLY

Morning	Mane	0800			
Night	Nocte			1800 or 2000	
Twice a day	BD	0800	2000		
Three times a day	TDS	0800	1400	2000	
Regular 6 hourly	6 hrly	0600	1200	1800	2400
Regular	8 hrly	0600	1400	2200	8 hourly
Four times a day	QID	0600	1200	1800	2200

Family Name:
Given Names:
Address:

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

Date of Birth: Sex: ☐M ☐F

REASON FOR NOT ADMINISTERING Codes MUST be circled	
Absent	A
Fasting	F
Refused - notify prescriber	R
Vomiting	V
On leave	L
Not available - enter reason in clinical record	N
Withheld - enter reason in clinical record	W
Self administered	S
Parent/Carer administered	P

YEAR 20............... DATE & MONTH →

PRESCRIBER MUST ENTER administration times

Date	Medicine & Strength (Print Generic Name)									
Route	Dose	Frequency & NOW enter times →								
Pharmacy/Additional Information										
Prescriber Signature	Print Your Name									
Date	Medicine & Strength (Print Generic Name)									
Route	Dose	Frequency & NOW enter times →								
Pharmacy/Additional Information										
Prescriber Signature	Print Your Name									
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Route	Dose	Frequency & NOW enter times →								
Pharmacy/Additional Information										
Prescriber Signature	Print Your Name									
Date	Medicine & Strength (Print Generic Name)									
Route	Dose	Frequency & NOW enter times →								
Pharmacy/Additional Information										
Prescriber Signature	Print Your Name									
Date	Medicine & Strength (Print Generic Name)									
Route	Dose	Frequency & NOW enter times →								
Pharmacy/Additional Information										
Prescriber Signature	Print Your Name									

AFFIX PATIENT IDENTIFICATION LABEL HERE AND OVERLEAF

Family Name:

Given Names:

Address:

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

Date of Birth: Sex: M ☐ F ☐

VERY SPECIAL kids

AS REQUIRED "PRN" MEDICATIONS

Weight (kg): ....

Date Weighed: ....

First Prescriber **to print patient name and check label correct:**

NOT VALID ORDER UNLESS LEGIBLE

Date	Medication & Strength (Print Generic Name)			Date								
Route	**DOSE**	Hourly Frequency PRN	Max Dose/24 hrs	Time								
Pharmacy Additional Information				**Dose**								
				Route								
Prescriber Signature	Print Your Name			Sign								
Date	Medication & Strength (Print Generic Name)			Date								
Route	**DOSE**	Hourly Frequency PRN	Max Dose/24 hrs	Time								
Pharmacy Additional Information				**Dose**								
				Route								
Prescriber Signature	Print Your Name			Sign								
Date	Medication & Strength (Print Generic Name)			Date								
Route	**DOSE**	Hourly Frequency PRN	Max Dose/24 hrs	Time								
Pharmacy Additional Information				**Dose**								
				Route								
Prescriber Signature	Print Your Name			Sign								
Date	Medication & Strength (Print Generic Name)			Date								
Route	**DOSE**	Hourly Frequency PRN	Max Dose/24 hrs	Time								
Pharmacy Additional Information				**Dose**								
				Route								
Prescriber Signature	Print Your Name			Sign								
Date	Medication & Strength (Print Generic Name)			Date								
Route	**DOSE**	Hourly Frequency PRN	Max Dose/24 hrs	Time								
Pharmacy Additional Information				**Dose**								
				Route								
Prescriber Signature	Print Your Name			Sign								
Date	Medication & Strength (Print Generic Name)			Date								
Route	**DOSE**	Hourly Frequency PRN	Max Dose/24 hrs	Time								
Pharmacy Additional Information				**Dose**								
				Route								
Prescriber Signature	Print Your Name			Sign								
Date	Medication & Strength (Print Generic Name)			Date								
Route	**DOSE**	Hourly Frequency PRN	Max Dose/24 hrs	Time								
Pharmacy Additional Information				**Dose**								
				Route								
Prescriber Signature	Print Your Name			Sign								

LONG STAY MEDICATION CHART

Place Photo Here

NAME OF GP

CONTACT NUMBER OF GP

AFFIX PATIENT IDENTIFICATION LABEL HERE AND OVERLEAF

Family Name:

Address:

NOT A VALID PRESCRIPTION
UNLESS IDENTIFIERS PRESENT

Date of Birth: Sex: M ☐ F ☐

PAEDIATRIC MEDICATION CHART NO. …… of ……..

ONCE ONLY MEDICINES

Date Prescribed	Medication (Print Generic Name)	Route	**DOSE**	Date/Time to be given	Prescriber		DOSE Calc eg. mg/kg Per Dose	Given by	Date/Time by
					Signature	Print your Name			

TELEPHONE ORDERS (To be signed within 24 hours of order)

Date	Time	Medication (Print Generic Name)	Route	Dose	Frequency	Nurse Initials 1	2	Dr Name	Dr Sign	Date	RECORD OF ADMINISTRATION Time Given By	Time Given By	Time Given By