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 ....

AFFIX PATIENT IDENTIFICATION LABEL HERE AND OVERLEAF

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

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

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

Date	Medicine (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:**

Date	Medication (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	Medicine (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 (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 (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 (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 (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 (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							

NOT VALID ORDER UNLESS LEGIBLE

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	Nurse Initials 2	Dr Name	Dr Sign	Date	**RECORD OF ADMINISTRATION** Time Given By	Time Given By	Time Given By