WA LONG STAY MEDICATION CHART

Cut Off Section

WA COUNTRY HEALTH SERVICE

Hospital Name Augusta

Ward 4A Team

Medication chart number 1 **of** 1

Additional charts ☐ Variable dose ☐ IV fluid ☐ BGL/insulin ☐ Acute pain ☐ Other ☐ Palliative care ☐ Chemotherapy ☐ Anticoagulation

ONCE ONLY, PRE-MEDICATION AND NURSE/MIDWIFE INITIATED MEDICINES

Date/Time prescribed	Medicine (print generic name)/form	Route	Dose	Date/Time of dose	Prescriber/Nurse/Midwife Initiator Signature	Print your name	Given by	Time Given	Pharmacy

TELEPHONE ORDER (to be signed within 24 hours of order)

Date/ Time	Medicine (print generic name)	Route	Dose	Frequency	Nurse/Midwife Initials 1st/2nd	Dr name	Dr Sign	Date	RECORD OF ADMINISTRATION Time/ Given by	Time/ Given by	Time/ Given by	Time/ Given by

Medicines taken prior to presentation to hospital

(Prescribed, over the counter, complementary)

☐ See WA MMP **Own medicines brought in?** Y ☐ N ☐ Administration aid (specify) ....

Medicine	Dose and frequency	Duration	Medicine	Dose and frequency	Duration

Not for administration

GP: **Community pharmacy:**

Sign: .... Print: .... Date: .... Medicines usually administered by: ....

Prescriber Details

	Prescriber 1	Prescriber 2	Prescriber 3	Prescriber 4	Prescriber 5	Prescriber 6
Name:						
Prescriber No.						
Contact No.						
Address:						
Signature:	Signature	Signature	Signature	Signature	Signature	Signature
Date:	Date	Date	Date	Date	Date	Date

Check if patient has another medication chart

WA Hospital Medication Chart - Long Stay

MR171

URN: M2435498
Family name: JOHNSON
Given names: RON
Address: 5555 DONOVAN ST, AUGUSTA, WA 6290
Date of birth: 9/1/1954 **Sex:** M ☒ F ☐

Not a valid prescription unless identifiers present

Attach ADR Sticker

See front page for details

First prescriber to print patient name and check label correct: RON JOHNSON

As required PRN medicines

Year ________

Start Date ..2.... /7......	Medicine (print generic name)/form Paracetamol 500mg	Date												
Route PO	Dose *and* hourly frequency PRN 2 tablets every 4 hours	Time												
Indication Lower back pain	Max PRN dose/24hr 4g	Dose												
SAC/AAN	Pharmacy Impress S8 S4R Max 8 tablets / 24hr	Route												
Prescriber signature L Marsh	Print Name Louise Marsh	Sign												

Continue on discharge? Y / N Dispense? Y / N Duration: .... days Qty: .... Prescriber's signature: .... Date: ....

Start Date ...... /	Medicine (print generic name)/form	Date												
Route	Dose *and* hourly frequency PRN	Time												
Indication	Max PRN dose/24hr	Dose												
SAC/AAN	Pharmacy Impress S8 S4R	Route												
Prescriber signature	Print Name	Sign												

Continue on discharge? Y / N Dispense? Y / N Duration: .... days Qty: .... Prescriber's signature: .... Date: ....

Start Date ...... /	Medicine (print generic name)/form	Date												
Route	Dose *and* hourly frequency PRN	Time												
Indication	Max PRN dose/24hr	Dose												
SAC/AAN	Pharmacy Impress S8 S4R	Route												
Prescriber signature	Print Name	Sign												

Continue on discharge? Y / N Dispense? Y / N Duration: .... days Qty: .... Prescriber's signature: .... Date: ....

Start Date ...... /	Medicine (print generic name)/form	Date												
Route	Dose *and* hourly frequency PRN	Time												
Indication	Max PRN dose/24hr	Dose												
SAC/AAN	Pharmacy Impress S8 S4R	Route												
Prescriber signature	Print Name	Sign												

Continue on discharge? Y / N Dispense? Y / N Duration: .... days Qty: .... Prescriber's signature: .... Date: ....

Start Date ...... /	Medicine (print generic name)/form	Date												
Route	Dose *and* hourly frequency PRN	Time												
Indication	Max PRN dose/24hr	Dose												
SAC/AAN	Pharmacy Impress S8 S4R	Route												
Prescriber signature	Print Name	Sign												

Continue on discharge? Y / N Dispense? Y / N Duration: .... days Qty: .... Prescriber's signature: .... Date: ....

Start Date ...... /	Medicine (print generic name)/form	Date												
Route	Dose *and* hourly frequency PRN	Time												
Indication	Max PRN dose/24hr	Dose												
SAC/AAN	Pharmacy Impress S8 S4R	Route												
Prescriber signature	Print Name	Sign												

Continue on discharge? Y / N Dispense? Y / N Duration: .... days Qty: .... Prescriber's signature: .... Date: ....

Pharmaceutical review:

Check if patient has another medication chart

DO NOT WRITE IN THIS BINDING MARGIN

XC100080

DO NOT WRITE IN THIS BINDING MARGIN

PBS Hospital Medication Chart – Long Stay – July 2016 – © Commonwealth of Australia 2016 – WA Version 2

Attach ADR Sticker

Allergies and adverse drug reactions (ADR)

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

Medicine (or other)	Reaction / Type / Date	Initials

Sign L Marsh Print Louise Marsh Date 2/7/YY

AFFIX PATIENT IDENTIFICATION LABEL HERE AND OVERLEAF

URN: M2435498
Family name: JOHNSON
Given names: RON
Address: 5555 DONOVAN ST, AUGUSTA, WA 6290
Date of birth: 9/1/1944
Sex: M ☒ F ☐

Not a valid prescription unless identifiers present

1st Prescriber to Print Patient Name and Check Label Correct:
RON JOHNSON

Weight (kg): ....
Height (cm): ....

Additional Charts – Tick if in use

- ☐ Insulin (☐ Subcutaneous or ☐ Intravenous Infusion)
- ☐ Intravenous (IV) Fluid ☐ Chemotherapy
- ☐ Acute Pain ☐ Palliative Care
- ☐ Clozapine ☐ Other ....

Venous Thromboembolism (VTE) risk assessment / Anticoagulation

☐ **VTE risk considered** (refer guidelines) ☐ **Bleeding risk considered**

Pharmacological Prophylaxis: ☐ Indicated* ☐ Not Indicated ☐ Contraindicated
*Consider surgical and anaesthetic implications prior to prescribing

Mechanical Prophylaxis: ☐ GCS ☐ IPC ☐ VFP ☐ Not Indicated ☐ Contraindicated

Risk Assessment completed by: (name)	Date/Time	Continue Y / N

If risk changes document VTE prophylaxis requirements on new chart

Key: GCS – Graduated Compression Stockings; IPC – Intermittent Pneumatic Compression; VFP – Venous Foot Pumps

☐ **Warfarin / Anticoagulant in use**
Refer to Anticoagulation Chart for administration details

Regular Medicines

Year ....

Date and month →
Prescriber to enter administration times ↓

Start Date ...... / ...... | Medicine (print generic name)/form | Tick if slow release
Route | Dose *and* Frequency | and now enter times →
Indication | Pharmacy | Imprest S8 S4R
Prescriber signature | Print name | SAC/AAN
Continue on discharge? Y / N | Dispense? Y / N | Duration: ......days Qty: ...... | Prescriber's signature: ...... | Date: ......

Start Date ...... / ...... | Medicine (print generic name)/form | Tick if slow release
Route | Dose *and* Frequency | and now enter times →
Indication | Pharmacy | Imprest S8 S4R
Prescriber signature | Print name | SAC/AAN
Continue on discharge? Y / N | Dispense? Y / N | Duration: ......days Qty: ...... | Prescriber's signature: ...... | Date: ......

Start Date ...... / ...... | Medicine (print generic name)/form | Tick if slow release
Route | Dose *and* Frequency | and now enter times →
Indication | Pharmacy | Imprest S8 S4R
Prescriber signature | Print name | SAC/AAN
Continue on discharge? Y / N | Dispense? Y / N | Duration: ......days Qty: ...... | Prescriber's signature: ...... | Date: ......

Start Date ...... / ...... | Medicine (print generic name)/form | Tick if slow release
Route | Dose *and* Frequency | and now enter times →
Indication | Pharmacy | Imprest S8 S4R
Prescriber signature | Print name | SAC/AAN
Continue on discharge? Y / N | Dispense? Y / N | Duration: ......days Qty: ...... | Prescriber's signature: ...... | Date: ......

Start Date ...... / ...... | Medicine (print generic name)/form | Tick if slow release
Route | Dose *and* Frequency | and now enter times →
Indication | Pharmacy | Imprest S8 S4R
Prescriber signature | Print name | SAC/AAN
Continue on discharge? Y / N | Dispense? Y / N | Duration: ......days Qty: ...... | Prescriber's signature: ...... | Date: ......

Start Date ...... / ...... | Medicine (print generic name)/form | Tick if slow release
Route | Dose *and* Frequency | and now enter times →
Indication | Pharmacy | Imprest S8 S4R
Prescriber signature | Print name | SAC/AAN
Continue on discharge? Y / N | Dispense? Y / N | Duration: ......days Qty: ...... | Prescriber's signature: ...... | Date: ......

Pharmaceutical review:

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 hourly	8 hrly	0600	1400	2200	
Four times a day	QID	0600	1200	1800	2200

Tick if Slow Release SR = Sustained, modified or controlled release formulation.
If scored tablet, then half can be given.
Dose must be swallowed without crushing.

REASON FOR NURSE/MIDWIFE NOT ADMINISTERING

Codes MUST be circled

Absent	A
Fasting	F
Refused – notify Dr	R
Vomiting	V
On leave	L
Not available – obtain supply or contact Dr	N
Withheld – enter reason in clinical record	W
Self Administered	S

WMR171 03/18

WACHS version March 2018