WA LONG STAY MEDICATION CHART

Cut Off Section

Hospital name.....
Hospital Provider number.....
Ward.....Team.....

Medication chart number ..... **of** .....

Additional charts
☐ IV fluid ☐ Variable dose ☐ BGL/insulin ☐ Chemotherapy ☐ Other (Refer to checklist on page 2) ☐ Acute pain ☐ Anticoagulation ☐ Palliative care

Chart valid for: ☐ 1 month ☐ 4 months ☐ 12 months
First prescriber to complete:

Initials:

Authority Prescription Number
XXXXXXXX

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	Date/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

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

MR XXX WA Hospital Medication Chart - Long Stay

URN:
Family name:
Given names:
Address:

Not a valid prescription unless identifiers present

Date of birth: **Sex:** M ☐ F ☐
Medicare No: **PBS/RPBS Entitlement No.**
☐ Concessional or dependent RPBS or Safety Net Concession Card Holder
☐ Safety Net Entitlement Card Holder

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

Approved pharmacy details:
.....
Pharmacy approval no:
.....

Attach ADR Sticker
See front page for details

As required "PRN" medicines

Brand substitution not permitted ☐ **PBS/RPBS** **Year** _____

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

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

(repeated 5 times)

Pharmaceutical review:

Check if patient has another medication chart

DO NOT WRITE IN THIS BINDING MARGIN

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 .... Print .... Date ....

AFFIX PATIENT IDENTIFICATION LABEL HERE AND OVERLEAF

URN:

Family name:

Given names:

Address:

Not a valid prescription unless identifiers present

Date of birth: **Sex:** **M** ☐ **F** ☐

Medicare No: **PBS/RPBS Entitlement No.**

☐ Concessional or dependent RPBS or Safety Net Concession Card Holder ☐ Safety Net Entitlement Card Holder

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

Weight (kg):............

Height (cm):............

Cut Off Section

EXAMPLE ONLY

Additional Charts – Tick if in use

☐ Blood Glucose Level (BGL) monitoring (☐ Subcutaneous insulin or ☐ Intravenous insulin infusion)

☐ Clozapine ☐ Intravenous (IV) Fluid ☐ Chemotherapy

☐ Agitation & arousal ☐ Palliative care ☐ Acute pain

☐ Long acting injection ☐ Variable dose ☐ 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

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	

Regular Medicines

Brand substitution not permitted ☐ **PBS/RPBS** **Year** ....

Date and month →

Prescriber MUST 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:

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

DO NOT WRITE IN THIS BINDING MARGIN

XXXX
11/23