Attach ADR Sticker

See page 3 for details

UR No:
Family name:
Given names:
Address:
DOB:
Sex ☐ M ☐ F

AFFIX PATIENT IDENTIFICATION LABEL HERE

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

INITIALS All staff to print name and designation beside initials

Initials	Print Name & Designation		Initials	Print Name & Designation		Initials	Print Name & Designation	

I request that my child ______________________ be immunised as per the National Immunisation Program.

I understand:

- the immunisation information supplied to me published by the Australian Government (Department of Health and Ageing Care)
- the benefits and risks of immunisation
- that I may withdraw permission for immunisation either verbally or in writing

Parent / Guardian Name ______________________ Parent / Guardian Signature ______________________

Date ______________

DO NOT WRITE IN MARGIN

DO NOT WRITE IN MARGIN

HCHKEFMR0811

KE114
01/14

Cut Off Section

Women and Newborn Health Service
King Edward Memorial Hospital

Ward/Unit: .... MEDICATION Chart No. .... of ....

MR811 NEONATAL INPATIENT MEDICATION CHART

ONCE ONLY AND PRE-MEDICATION DRUGS

Date/Time to be given	Medication (print generic name)	DOSE calc e.g. mg/kg per DOSE	Route	DOSE	Prescriber Signature	Prescriber Print Name	Given by	Date/Time given	Pharm

AS REQUIRED "PRN" MEDICATIONS

Date	Medication (Print Generic Name)				Date									
Route	DOSE	Hourly Frequency PRN	Max DOSE/24 hrs		Time									
Pharmacy/Additional Information					DOSE									
Indicaiton		Calculation of DOSE (eg. mg/kg/DOSE)			Route									
Prescriber Signature	Print Your Name		Contact		Sign									

DISCHARGE DRUGS

WEIGHT AT DISCHARGE .... g

Date	Drug (approved name)	Dose and Frequency	Period of supply	Doctor Name / Doctor Signature	Pharmacist

All medication must be checked by two people. The person administering the medication must initial the top box. The person checking is required to initial the bottom box.

KE114 HCHKEFMR0811 FOB BLACK, PMS 032 Red

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ALLERGIES AND ADVERSE DRUG REACTIONS (ADR)

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

Drug (or other)	Reaction/Type/Date	Initials

Complete hospital ADR and alert requirements

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

UR No:

Family name:

Given names:

Address:

AFFIX PATIENT IDENTIFICATION LABEL HERE

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

DOB: **Sex** ☐ **M** ☐ **F**

1st Prescriber to print patient name and check label correct:

Patient Name .....

Date ..... **Gest Age** ..... **CGA** .....

BW ..... **Working Wt** .....

REGULAR MEDICATIONS

Doctor must enter administration times

YEAR 20..... **DATE & MONTH** → | **Time**

Date | Medication (print generic name)

Route | DOSE | Frequency & enter times →

Indication | Dose Calculation (e.g. mg/kg per DOSE)

Prescriber signature | Print Name

Pharmacy | Additional Information

(repeated)

Pharmacist review:

NOT A VALID ORDER UNLESS LEGIBLE

RECOMMENDED ADMINISTRATION TIMES
GUIDELINES ONLY

Morning	Mane	0800				
Night	Nocte				2000	
Twice a day	BD	0800		2000		
		0200		1400		
Regular 6 hourly	6 hrly	0200	0800	1400	2000	
Regular 8 hourly	8 hrly	0800	1600	2400		

REASON FOR NURSE NOT ADMINISTERING
Codes MUST be circled

Fasting	(F)
Vomiting	(V)
On leave	(L)
Not available – obtain supply or contact Doctor	(N)
Withheld – enter reason in clinical record	(W)
Parent/Carer Administered	(P)

All medication must be checked by two people. The person administering the medication must initial the top box. The person checking is required to initial the bottom box.

REGULAR MEDICATIONS

Doctor must enter administration times

All medication must be checked by two people. The person administering the medication must initial the top box. The person checking is required to initial the bottom box.

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