8 Day National Medication Chart

Chart ____ of ____

Date Recharted _____
Day Month Year

Family Name: _____

Given Name: _____ Gender: _____

AFFIX PATIENT LABEL HERE

Date of Birth: _____ NHI#: _____

Prescriber to write Patient's name and NHI:

_____

Allergies

No ☐

Medication / Other	Reaction
Signature	**Date**
New on this admission	
Signature	**Date**

Adverse Reactions

No ☐

Medication	Reaction
Signature	**Date**
New on this admission	
Signature	**Date**

Special Care Required

No ☐

- ☐ Renal impairment
- ☐ Hepatic impairment
- ☐ Other: _____
- ☐ Pregnancy
- ☐ Breastfeeding

Supplementary Charts

No ☐

- ☐ Diabetic/Insulin
- ☐ Heparin
- ☐ Other: _____
- ☐ Specialised analgesia
- ☐ Warfarin

Sample Signature – Prescribers

Sample Initials – Administrators/Others

NAME & DESIGNATION (family & given)	SIGNATURE	REG. No.	NAME & DESIGNATION (family & given)	INITIAL	REG. No.

DO NOT WRITE IN THIS AREA

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Allergies	No ☐	Adverse Reactions	No ☐
Yes ☐	List medicine(s):	Yes ☐	List medicine(s):
Refer to front page for details		Initials	

Family Name: _____

Given Name: _____ Gender: _____

AFFIX PATIENT LABEL HERE

Date of Birth: _____ NHI#: _____

Weight (kg) _____ Date _____	Weight (kg) _____ Date _____

Height (cm) _____ Date _____	B.S.A (m²) _____	Gestational age at birth (wks) _____

ONCE ONLY

Once Only

Date	Medicine						Given by / Checked by
	Dose ___ • ___	Units	Route	Dose calculation (eg. mg/kg per dose)	Prescriber's signature	Time commenced	
	Dose range if needed		Date & time of dose		Pharmacy & special instructions	Pharm / Time completed	

Date	Medicine						Given by / Checked by
	Dose ___ • ___	Units	Route	Dose calculation (eg. mg/kg per dose)	Prescriber's signature	Time commenced	
	Dose range if needed		Date & time of dose		Pharmacy & special instructions	Pharm / Time completed	

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	Dose range if needed		Date & time of dose		Pharmacy & special instructions	Pharm / Time completed	

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	Dose range if needed		Date & time of dose		Pharmacy & special instructions	Pharm / Time completed	

Date	Medicine						Given by / Checked by
	Dose ___ • ___	Units	Route	Dose calculation (eg. mg/kg per dose)	Prescriber's signature	Time commenced	
	Dose range if needed		Date & time of dose		Pharmacy & special instructions	Pharm / Time completed	

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	Dose ___ • ___	Units	Route	Dose calculation (eg. mg/kg per dose)	Prescriber's signature	Time commenced	
	Dose range if needed		Date & time of dose		Pharmacy & special instructions	Pharm / Time completed	

Date	Medicine						Given by / Checked by
	Dose ___ • ___	Units	Route	Dose calculation (eg. mg/kg per dose)	Prescriber's signature	Time commenced	
	Dose range if needed		Date & time of dose		Pharmacy & special instructions	Pharm / Time completed	

DO NOT WRITE IN THIS AREA

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Family Name: _____

Given Name: _____ Gender: _____

AFFIX PATIENT LABEL HERE

Date of Birth: _____ NHI#: _____

Once Only

Date	Medicine						Given by / Checked by
	Dose ____ • ____	Units	Route	Dose calculation (eg. mg/kg per dose)	Prescriber's signature	Time commenced	
	Dose range if needed		Date & time of dose		Pharmacy & special instructions	Pharm / Time completed	

Date	Medicine						Given by / Checked by
	Dose ____ • ____	Units	Route	Dose calculation (eg. mg/kg per dose)	Prescriber's signature	Time commenced	
	Dose range if needed		Date & time of dose		Pharmacy & special instructions	Pharm / Time completed	

Date	Medicine						Given by / Checked by
	Dose ____ • ____	Units	Route	Dose calculation (eg. mg/kg per dose)	Prescriber's signature	Time commenced	
	Dose range if needed		Date & time of dose		Pharmacy & special instructions	Pharm / Time completed	

Date	Medicine						Given by / Checked by
	Dose ____ • ____	Units	Route	Dose calculation (eg. mg/kg per dose)	Prescriber's signature	Time commenced	
	Dose range if needed		Date & time of dose		Pharmacy & special instructions	Pharm / Time completed	

Verbal Orders (must be signed as soon as possible or within 24 hours of order)

Date & Time	Medicine							Given by / Checked by
	Dose ____ • ____	Units	Route	Dose calculation (eg. mg/kg per dose)	Date & time of dose	Initials: Nurse / Initials: Witness	Time commenced / Time completed	
	Dose range if needed		Prescriber's name		Prescriber's signature	Pharmacy & Special Instructions	Pharm	

Date & Time	Medicine							Given by / Checked by
	Dose ____ • ____	Units	Route	Dose calculation (eg. mg/kg per dose)	Date & time of dose	Initials: Nurse / Initials: Witness	Time commenced / Time completed	
	Dose range if needed		Prescriber's name		Prescriber's signature	Pharmacy & Special Instructions	Pharm	

Oxygen Therapy & Medical Gases

Target Oxygen Saturation (%):

START DATE	DEVICE/DELIVERY	FLOW RATE	SIGNATURE	STOP DATE

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As Required (PRN) Medicines

Date	Medicine						
	Dose ____ • ____	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)	Max dose/24hrs	Prescriber's signature
A	Dose range if needed		Indication	Pharmacy & special instructions		Pharm	Sign, date and time to cancel

Date	Medicine						
	Dose ____ • ____	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)	Max dose/24hrs	Prescriber's signature
B	Dose range if needed		Indication	Pharmacy & special instructions		Pharm	Sign, date and time to cancel

Date	Medicine						
	Dose ____ • ____	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)	Max dose/24hrs	Prescriber's signature
C	Dose range if needed		Indication	Pharmacy & special instructions		Pharm	Sign, date and time to cancel

Date	Medicine						
	Dose ____ • ____	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)	Max dose/24hrs	Prescriber's signature
D	Dose range if needed		Indication	Pharmacy & special instructions		Pharm	Sign, date and time to cancel

Date	Medicine						
	Dose ____ • ____	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)	Max dose/24hrs	Prescriber's signature
E	Dose range if needed		Indication	Pharmacy & special instructions		Pharm	Sign, date and time to cancel

Date	Medicine						
	Dose ____ • ____	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)	Max dose/24hrs	Prescriber's signature
F	Dose range if needed		Indication	Pharmacy & special instructions		Pharm	Sign, date and time to cancel

Date	Medicine						
	Dose ____ • ____	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)	Max dose/24hrs	Prescriber's signature
G	Dose range if needed		Indication	Pharmacy & special instructions		Pharm	Sign, date and time to cancel

Date	Medicine						
	Dose ____ • ____	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)	Max dose/24hrs	Prescriber's signature
H	Dose range if needed		Indication	Pharmacy & special instructions		Pharm	Sign, date and time to cancel

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PRN

DO NOT WRITE IN THIS AREA

Date	Time	Dose	Route	Giv/Chck	Date	Time	Dose	Route	Giv/Chck	Date	Time	Dose	Route	Giv/Chck	Date	Time	Dose	Route	Giv/Chck
		A																	
		B																	
		C																	
		D																	
		E																	
		F																	
		G																	
		H																	

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IF CHART IS TO BE SCANNED PLEASE ENTER PATIENT NAME: _____ NHI: _____

VENOUS THROMBOEMBOLISM (VTE) PREVENTION

Assess VTE risk on admission, again within 24 – 48 hours of admission, and periodically when/if the patient's clinical condition changes significantly.

VTE risk assessed on admission ☐ Date: _____ Prescriber's signature: _____

VTE risk reassessed	Date:	Signature:	Date:	Signature:	Date:	Signature:

If NO VTE prophylaxis prescribed – state reason why:

Low risk of VTE: ☐ High bleeding risk: ☐

Other: .....

.....

VTE prophylaxis prescribed:

Anticoagulation prescribed: Yes ☐ No ☐

Mechanical VTE prophylaxis prescribed:

Graduated compression stockings: Yes ☐ No ☐

Intermittent pneumatic compression devices: Yes ☐ No ☐

Regular Medicine

Date	Medicine	Dose	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)	Prescriber's signature	Dose range if needed	Pharmacy & special instructions	Pharm	Sign, date and time to cancel	Circle or actual time	
I												0600	
												0800	
												1400	
												1800	
												2200	
J												0600	
												0800	
												1400	
												1800	
												2200	
K												0600	
												0800	
												1400	
												1800	
												2200	
L												0600	
												0800	
												1400	
												1800	
												2200	
M												0600	
												0800	
												1400	
												1800	
												2200	
N												0600	
												0800	
												1400	
												1800	
												2200	
O												0600	
												0800	
												1400	
												1800	
												2200	

DO NOT WRITE IN THIS AREA

Family Name: _____

Given Name: _____ Gender: _____

AFFIX PATIENT LABEL HERE

Date of Birth: _____ NHI#: _____

REGULAR 1

DO NOT WRITE IN THIS AREA

Date			Date			Date			Date			Date			Date			Date			Date		
Time	Dose	Giv/Chck	Time	Dose	Giv/Chck	Time	Dose	Giv/Chck	Time	Dose	Giv/Chck	Time	Dose	Giv/Chck	Time	Dose	Giv/Chck	Time	Dose	Giv/Chck	Time	Dose	Giv/Chck
	I																						
	J																						
	K																						
	L																						
	M																						
	N																						
	O																						

PRESCRIBER TO RE-WRITE MEDICATION CHART

Regular Medicine

								Circle or actual time	
Date	Medicine							0600	
								0800	
	Dose ___ • ___	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)	Prescriber's signature		1400	
	Dose range if needed		Pharmacy & special instructions				Pharm	1800	
P						Sign, date and time to cancel		2200	

Date	Medicine							0600	
								0800	
	Dose ___ • ___	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)	Prescriber's signature		1400	
	Dose range if needed		Pharmacy & special instructions				Pharm	1800	
Q						Sign, date and time to cancel		2200	

Date	Medicine							0600	
								0800	
	Dose ___ • ___	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)	Prescriber's signature		1400	
	Dose range if needed		Pharmacy & special instructions				Pharm	1800	
R						Sign, date and time to cancel		2200	

Date	Medicine							0600	
								0800	
	Dose ___ • ___	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)	Prescriber's signature		1400	
	Dose range if needed		Pharmacy & special instructions				Pharm	1800	
S						Sign, date and time to cancel		2200	

Date	Medicine							0600	
								0800	
	Dose ___ • ___	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)	Prescriber's signature		1400	
	Dose range if needed		Pharmacy & special instructions				Pharm	1800	
T						Sign, date and time to cancel		2200	

Date	Medicine							0600	
								0800	
	Dose ___ • ___	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)	Prescriber's signature		1400	
	Dose range if needed		Pharmacy & special instructions				Pharm	1800	
U						Sign, date and time to cancel		2200	

Date	Medicine							0600	
								0800	
	Dose ___ • ___	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)	Prescriber's signature		1400	
	Dose range if needed		Pharmacy & special instructions				Pharm	1800	
V						Sign, date and time to cancel		2200	

Date	Medicine							0600	
								0800	
	Dose ___ • ___	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)	Prescriber's signature		1400	
	Dose range if needed		Pharmacy & special instructions				Pharm	1800	
W						Sign, date and time to cancel		2200	

DO NOT WRITE IN THIS AREA

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IF CHART IS TO BE SCANNED PLEASE ENTER
PATIENT NAME: _____ NHI: _____

DO NOT WRITE IN THIS AREA

Date			Date			Date			Date			Date			Date			Date			Date		
Time	Dose	Giv/Chck	Time	Dose	Giv/Chck	Time	Dose	Giv/Chck	Time	Dose	Giv/Chck	Time	Dose	Giv/Chck	Time	Dose	Giv/Chck	Time	Dose	Giv/Chck	Time	Dose	Giv/Chck
	P																						
	Q																						
	R																						
	S																						
	T																						
	U																						
	V																						
	W																						

PRESCRIBER TO RE-WRITE MEDICATION CHART

Regular Medicine

								Circle or actual time	
Date	Medicine							0600	
								0800	
	Dose ____ • ____	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)		Prescriber's signature	1400	
	Dose range if needed		Pharmacy & special instructions			Pharm	Sign, date and time to cancel	1800	
X								2200	

Date	Medicine							0600	
								0800	
	Dose ____ • ____	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)		Prescriber's signature	1400	
	Dose range if needed		Pharmacy & special instructions			Pharm	Sign, date and time to cancel	1800	
Y								2200	

Date	Medicine							0600	
								0800	
	Dose ____ • ____	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)		Prescriber's signature	1400	
	Dose range if needed		Pharmacy & special instructions			Pharm	Sign, date and time to cancel	1800	
Z								2200	

Date	Medicine							0600	
								0800	
	Dose ____ • ____	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)		Prescriber's signature	1400	
	Dose range if needed		Pharmacy & special instructions			Pharm	Sign, date and time to cancel	1800	
AA								2200	

Date	Medicine							0600	
								0800	
	Dose ____ • ____	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)		Prescriber's signature	1400	
	Dose range if needed		Pharmacy & special instructions			Pharm	Sign, date and time to cancel	1800	
AB								2200	

Date	Medicine							0600	
								0800	
	Dose ____ • ____	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)		Prescriber's signature	1400	
	Dose range if needed		Pharmacy & special instructions			Pharm	Sign, date and time to cancel	1800	
AC								2200	

Date	Medicine							0600	
								0800	
	Dose ____ • ____	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)		Prescriber's signature	1400	
	Dose range if needed		Pharmacy & special instructions			Pharm	Sign, date and time to cancel	1800	
AD								2200	

Date	Medicine							0600	
								0800	
	Dose ____ • ____	Units	Route	Frequency	Dose calculation (eg. mg/kg per dose)		Prescriber's signature	1400	
	Dose range if needed		Pharmacy & special instructions			Pharm	Sign, date and time to cancel	1800	
AE								2200	

DO NOT WRITE IN THIS AREA

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GENERAL INSTRUCTIONS

1. Use **indelible pen** only to write on this chart.
2. All users must **complete the Sample Signature/Initial Register**.
3. **Reg. No.** – registration number.

Prescriber's Instructions

1. Use approved or generic names only and prescribe using block capitals.
2. Full signature.
3. To **stop** a medication, enter the stop date, time, sign, and cross through order and administration.
4. To **alter** therapy, stop the original order as per instruction 3 above, and prescribe on a new line.

Administrator's Instructions

1. Record time of administration using 24-hour clock.
2. For variable dose, record actual dose given.
3. For variable route, record actual route used.
4. If dose not given, record appropriate non-administration code.
5. Giv/Chck – given by/checked by.

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	
Antibiotic 8 hourly	q8h	0600	1400	2200	
Antibiotic 6 hourly	q6h	0600	1200	1800	2400
Four times a day	QID	0600	1200	1800	2200

NON-ADMINISTRATION CODES

U	Patient unavailable
SM	Self-medicating
CP	Carer/Parent
R	Patient refused
D	Prescriber's instructions
N	Not administered – document reason in notes

REGULAR 3

DO NOT WRITE IN THIS AREA

Date			Date			Date			Date			Date			Date			Date			Date		
Time	Dose	Giv/Chck	Time	Dose	Giv/Chck	Time	Dose	Giv/Chck	Time	Dose	Giv/Chck	Time	Dose	Giv/Chck	Time	Dose	Giv/Chck	Time	Dose	Giv/Chck	Time	Dose	Giv/Chck
	X																						
	Y																						
	Z																						
	AA																						
	AB																						
	AC																						
	AD																						
	AE																						

PRESCRIBER NOTE-WRITE MEDICATION CHART

Allergy/ Adverse Reaction Information

Refer Front Page

INTRAVENOUS AND SUBCUTANEOUS FLUID PRESCRIPTION AND INFUSION RECORD

Family Name: _____

Given Name: _____ Gender: _____

AFFIX PATIENT LABEL HERE

Date of Birth: _____ NHI#: _____

Date	Prescribed Commencing Time	Volume (mL)	Intravenous and Subcutaneous Fluid and Additives	Route	Rate (mL / hr)	Prescriber's Signature	Actual Commencing Time	Commenced By / Checked By	Completion	
									Time	Actual Vol.

DO NOT WRITE IN THIS AREA