PATIENT'S NAME..... HEALTH RECORD NUMBER.....

MORNING (around 0800); MIDDAY (between 1200 & 1400); EVENING (around 1800); BEDTIME (around 2200)

AS REQUIRED MEDICINES

DATE	MEDICINE (Approved Name)	PHARMACIST / SUPPLY	DOSE	ROUTE	FREQUENCY	MAXIMUM DOSE IN 24 HRS	PRESCRIBER'S SIGNATURE	INDICATION	bleep No.

DATE	TIME GIVEN	DOSE / ROUTE	GIVEN BY	DATE	TIME GIVEN	DOSE / ROUTE	GIVEN BY	DATE	TIME GIVEN	DOSE / ROUTE	GIVEN BY	DISCHARGE PRESCRIPTION
												To be reviewed by GP / Continuous
												Limited Duration ..... days
												Other Instructions
												To be reviewed by GP / Continuous
												Limited Duration ..... days
												Other Instructions
												To be reviewed by GP / Continuous
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												Other Instructions
												To be reviewed by GP / Continuous
												Limited Duration ..... days
												Other Instructions

NON-ADMINISTRATION OF MEDICINES

When a patient does not receive a prescribed dose, the nurse should enter one of the code numbers given below in the administration box, to explain the reason for non-administration. Please attempt to obtain any unavailable medicines.

X. Prescriber's request
1. Patient not on ward
3. Patient unable to receive medicines/or no access
4. Patient refused medicine
5. Medicine unavailable
6. See Notes

Prescriber's Signature authorising TTO	Bleep No.	Date	Pharmacy Date

PATIENT'S NAME..... HEALTH RECORD NUMBER.....

INTRAVENOUS AND SUBCUTANEOUS INFUSIONS

INFUSIONS TO BE ADMINISTERED ONCE ONLY, UNLESS THE PRESCRIBER SPECIFIES THEY ARE TO BE CONTINUOUS*

DATE & START	INFUSION FLUID: TYPE / STRENGTH	INFUSION FLUID: VOLUME	ROUTE	MEDICINE ADDED: APPROVED NAME	MEDICINE ADDED: DOSE	INFUSION RATE OR DURATION	PRESCRIBER'S SIGNATURE	PHARM	TIME: START	TIME: STOP	VOL GIVEN	GIVEN BY	CH'KD BY
Batch No.	Device No.			*Prescriber to initial if continuous			bleep No.						
Batch No.	Device No.			*Prescriber to initial if continuous			bleep No.						
Batch No.	Device No.			*Prescriber to initial if continuous			bleep No.						
Batch No.	Device No.			*Prescriber to initial if continuous			bleep No.						
Batch No.	Device No.			*Prescriber to initial if continuous			bleep No.						
Batch No.	Device No.			*Prescriber to initial if continuous			bleep No.						
Batch No.	Device No.			*Prescriber to initial if continuous			bleep No.						
Batch No.	Device No.			*Prescriber to initial if continuous			bleep No.						
Batch No.	Device No.			*Prescriber to initial if continuous			bleep No.						

Royal College of Physicians

IN-PATIENT MEDICATION ADMINISTRATION RECORD

Developed in collaboration with the All Wales Chief Pharmacists Committee

GIG CYMRU NHS WALES

DRUG ALLERGIES & SENSITIVITIES

PLEASE CIRCLE AS APPROPRIATE: NONE KNOWN YES

SIGNED..... DATE.....

NAME.....

Drug / Allergen:	Description of Reaction:

This section must usually be completed prior to administration of any medicine. Refer to local policies for further guidance.

HOSPITAL No: .....

SURNAME: .....

FIRST NAME: .....

ADDRESS: .....

ADDRESSOGRAPH

DATE OF BIRTH: .....

Height (m)			Weight (kg)			Surface Area (m²)
Date	Height	Sign	Date	Weight	Sign	
			Date	Weight	Sign	

DATE OF ADMISSION .....

HOSPITAL .....

WARD .....

CONSULTANT .....

MULTIPLE MEDICATION CHARTS CHART .....

OF .....

MEDICATION ON SUPPLEMENTARY CHARTS SHOULD ALSO BE RECORDED ON THIS DRUG CHART.

DETAILS OF SUPPLEMENTARY CHARTS
TICK APPROPRIATE BOX

- ANTICOAGULANT ☐
- SUPPLEMENTARY INFUSION CHART ☐
- INSULIN ☐
- PATIENT CONTROLLED ANALGESIA/EPIDURAL ☐
- SYRINGE DRIVER ☐
- OTHER (PLEASE SPECIFY)

Venous Thromboembolism Risk Assessment

	(Y/N)	Signature	Date
Does the patient need thromboprophylaxis? (Refer to local policy)			

If **YES,** please prescribe appropriate thromboprophylaxis on the prescription chart

If thromboprophylaxis contraindicated, please state reason: .....

(N.B. Reassess risk of bleeding and venous thromboembolism within 24 hours and if clinical situation changes)

PRESCRIPTIONS FOR ONCE ONLY and PRE-ANAESTHETIC MEDICATION

DATE	MEDICINE (APPROVED NAME)	DOSE	ROUTE	TIME TO BE GIVEN	PRESCRIBERS SIGNATURE	PHARMACY	DATE	TIME GIVEN	GIVEN BY	CHECKED BY
					bleep No					
					bleep No					
					bleep No					
					bleep No					
					bleep No					
					bleep No					
					bleep No					
					bleep No					
					bleep No					

MEDICINES MANAGEMENT

MEDICATION HISTORY OBTAINED FROM:
PATIENT ☐ GP ☐ NH/RH ☐ CARER ☐
PODS ☐ MDS ☐ OTHER .....

COMPLIANCE ISSUES .....

INITIALS ..... DATE .....

MEDICINES RECONCILED

INITIALS ..... DATE .....

GP

COMMUNITY PHARMACY DETAILS

COMMENTS / NOTES

DISCHARGE PRESCRIPTION WRITTEN

INITIALS ..... DATE .....

IN-PATIENT MEDICATION ADMINISTRATION RECORD

AWMR06.12

SAMPLE

PATIENT'S NAME ..... HEALTH RECORD NUMBER .....

MORNING (around 0800); MIDDAY (between 1200 & 1400); EVENING (around 1800): BEDTIME (around 2200)

ENTER DOSE AGAINST TIME REQUIRED. USE ONE ROUTE ONLY FOR EACH ENTRY

REGULAR MEDICINES — MONTH — YEAR — DATE

DISCHARGE PRESCRIPTION

MEDICINE (Approved Name): **OXYGEN**

SPECIAL INSTRUCTIONS: Sign box to indicate that specified target saturations have been checked and achieved. Adjust flow rate and/ or delivery device as necessary. Refer to Local Policy for further details.

PRESCRIBER'S SIGNATURE — bleep No. — DATE — PHARMACY

Circle Saturation target

88-92%

94-98%

Other .....

MORNING — MIDDAY — EVENING — BEDTIME

RE-WRITE CHART

DATE → ROUTE → SPECIFY TIME IF REQUIRED ↓ — DOSE ↓ — SIGN — DOSE CHANGE ↓

MEDICINE (Approved Name) — SPECIAL INSTRUCTIONS — PRESCRIBER'S SIGNATURE — bleep No. — PHARMACIST — SUPPLY

Morning — Midday — Evening — Bedtime

To be reviewed by GP — Continuous — Limited Duration — days — Other Instructions

CHART MUST BE RE-WRITTEN BEFORE FURTHER DOSES ARE ADMINISTERED

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Prescriber's Signature authorising TTO — Bleep No. — Date — Pharmacy Date

PATIENT'S NAME ..... HEALTH RECORD NUMBER .....

MORNING (around 0800); MIDDAY (between 1200 & 1400); EVENING (around 1800): BEDTIME (around 2200)

ENTER DOSE AGAINST TIME REQUIRED. USE ONE ROUTE ONLY FOR EACH ENTRY

REGULAR MEDICINES — MONTH — YEAR — DATE

DISCHARGE PRESCRIPTION

DATE → ROUTE → SPECIFY TIME IF REQUIRED ↓ — DOSE ↓ — SIGN — DOSE CHANGE ↓

MEDICINE (Approved Name) — SPECIAL INSTRUCTIONS — PRESCRIBER'S SIGNATURE — bleep No. — PHARMACIST — SUPPLY

Morning — Midday — Evening — Bedtime

To be reviewed by GP — Continuous — Limited Duration — days — Other Instructions

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REGULAR MEDICINES — MONTH — YEAR — DATE

DISCHARGE PRESCRIPTION

DATE → ROUTE → SPECIFY TIME IF REQUIRED ↓ — DOSE ↓ — SIGN — DOSE CHANGE ↓

MEDICINE (Approved Name) — SPECIAL INSTRUCTIONS — PRESCRIBER'S SIGNATURE — bleep No. — PHARMACIST — SUPPLY

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SAMPLE