INTERIM MEDICATION ADMINISTRATION CHART

easternhealth

Page ___ of ___

UR Number: _		
Surname:		
Given Name:		
Date of Birth:		Sex: M / F
	Affix Hospital ID Label If Available	e.

practitio	ner (wi	thin 7 days of ho	spital	discharg	e)	lication	Charts	<u>s.</u> It is	Offity to	J De u	seu ui	illi li le	patient is rev	viewed by His/Hei genera
	SE RE (nown	ACTIONS (ADR))											
Drug (o	r othe				Reaction/	Date								Initials
Sign.	Sign. Print: Date:													
DATE ADMINISTRATION TIMES				→								CHANGE S	TATUS	
SIGN TI	HIS SE	ECTION FOR MU	LTI-D	OSE										
ADMINI (e.g. Multi-			-			 	ļ!							BER TO COMPLETE
(e.g. Mulli-	uose biis	ter pack)	7			_							 	
													I 	•
		FOR INDIVIDUA ADMINISTRATION		1		+							ı [
Date	Medicatio	on (Print Generic Name)	1	Tick If Slow										
Route	Dose	Frequency		Release	_	1	<u> </u>							
						+								
Pharmacy		Indication				1								
Prescriber Si	ignature	Print your name	Prescri	iber No.		+								
D. I.	Madhad	(Print County Name)												
Date	Medicatio	on (Print Generic Name)		Tick If Slow Release]									
Route	Dose	Frequency												
Pharmacy Indication					-									
Prescriber Si	gnature	Print your name	Prescrit	iber No.		_								
Date	Medicatio	on (Print Generic Name)	ı	Tick If Slow										
Route	Dose	Frequency		Release										
riouto	2000	. roquonoy												
Pharmacy		Indication												
Prescriber Si	ignature	Print your name	Prescrit	iber No.		+	 							

August 2020 Version 1

Signature: Name (please print): Designation:

Date:

INTERIM MEDICATION ADMINISTRATION CHART E356070

INTERIM MEDICATION ADMINISTRATION CHART

easternhealth

Page ___ of ___

UR Number:			
Surname:			
Given Name: _			
Date of Birth: _	/		Sex: M / F
	Affix Hospi	ital ID Label If Ava	nilable

INTERIM MEDICATION ADMINISTRATION CHART E356070

This interim medication chart <u>replaces all previous medication charts.</u> It is only to be used until the patient is reviewed by

his/her gei	neral practitioner (wi	thin 7 da	ys of hos	pital c	discha	arge)							
ALLERGIE	S & ADVERSE REACT	TIONS (A	DR)										
Drug (or ot	her)		Reaction	/Date								Initials	
Sign. Print:							Date:						
AS REQUIF	RED "PRN" MEDICAT	IONS											
			ADMNIS	TRA	τιον ι	DETAI	LS				CHANGE STATUS		
Date	Medication (Print Generic Name)		Date										
		1	Time										
Route	Dose and Hourly Frequency PRN	Max Dose/24hr	Dose	<u> </u>									
			Sign	<u> </u>									
Pharmacy	Indication		Date										
			Time	<u> </u>									
Prescriber Signature	Print your name	Prescriber No.	Dose						<u> </u>				
			Sign										
Date	Medication (Print Generic Name)		Date										
			Time				 	 	_ 	 			
Route	Dose and Hourly Frequency	Max Dose/24hr	Dose										
	PRN		Sign										
Pharmacy	Indication		Date										
			Time										
Prescriber Signature	Print your name	Prescriber No.	Dose										
			Sign										
Date	Medication (Print Generic Name)		Date										
			Time										
Route	Dose and Hourly Frequency	Max Dose/24hr	Dose	<u> </u>	<u> </u>								
	PRN		Sign										
Pharmacy	Indication		Date	<u> </u>	<u> </u>								
		T	Time	<u> </u>	<u> </u>								
Prescriber Signature	Print your name	Prescriber No.	Dose										
			Sign	1			()			1 1			

Signature: Name (please print): Designation: Date:

INTERIM MEDICATION ADMINISTRATION CHART E356070

easternhealth

INTERIM MEDICATION **ADMINISTRATION CHART**

UR Number:			
Surname:			
Given Name:			
Date of Birth:	/	Sex:	M / F
	Affix Hospital ID Label If Available		

Pa	ge of		Affix Hospital ID Label If Available						
				ous medication ch r (within 7 days of h					
ALLERGIES & ADV	ERSE REACTION	S (ADR)							
Drug (or other)		Reaction/Dat	te				Initials		
Sign.	Print:			Date:					
without further me	edical advice.	SPITAL- Th	ese	medications have b		_			
Medication (print	generic name)			Date Ceased (if known)	Re	easo	n (if known)		
Medication	Dose								
Medication	Dose								
Medication	Dose								
Medication	Dose								
Medication	Dose								
Medication	Dose								
Medication	Dose								
MEDICATIONS W	ITHHELD IN HO	SPITAI - Thes	se m	edications have been	temporaril	v witl	hheld		
				Plan on discharge		y with	illiola		
Medication	Dose								
Medication	Dose								
Medication	Dose								
Medication	Dose								
Medication	Dose								
Medication	Dose								
Medication	Dose								

Doctor Name:	Contact:
Doctor Signature:	
Eastern Health Site:	
	·

Signature:	Name (please print):	Designation:	Date [.]	

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