easternhealth

INTERIM MEDICATION ADMINISTRATION CHART

Page ___ of ___

UR Number: ______________________________

Surname: ______________________________

Given Name: ______________________________

Date of Birth: ________/________/_______ Sex: M / F

Affix Hospital ID Label If Available

FEH356070

This interim medication chart **replaces all previous medication charts.** It is only to be used until the patient is reviewed by his/her general practitioner (within 7 days of hospital discharge)

ADVERSE REACTIONS (ADR)

☐ **Nil Known**

Drug (or other)	Reaction/Date	Initials

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

DATE → ADMINISTRATION TIMES ↓								CHANGE STATUS
SIGN THIS SECTION FOR MULTI-DOSE ADMINISTRATION (e.g. Multi-dose blister pack) →								PRESCRIBER TO COMPLETE THIS SECTION ↓
SIGN BELOW FOR INDIVIDUAL MEDICATION ADMINISTRATION ↓								
Date / Medication (Print Generic Name) / Tick If Slow Release ☐								
Route / Dose / Frequency								
Pharmacy / Indication								
Prescriber Signature / Print your name / Prescriber No.								
Date / Medication (Print Generic Name) / Tick If Slow Release ☐								
Route / Dose / Frequency								
Pharmacy / Indication								
Prescriber Signature / Print your name / Prescriber No.								
Date / Medication (Print Generic Name) / Tick If Slow Release ☐								
Route / Dose / Frequency								
Pharmacy / Indication								
Prescriber Signature / Print your name / Prescriber No.								

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

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ALLERGIES & ADVERSE REACTIONS (ADR)

☐ Nil Known

Drug (or other)	Reaction/Date	Initials

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

AS REQUIRED "PRN" MEDICATIONS

			ADMNISTRATION DETAILS								CHANGE STATUS
Date	Medication (Print Generic Name)		Date								
			Time								
Route	Dose and Hourly Frequency PRN	Max Dose/24hr	Dose								
			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 PRN	Max Dose/24hr	Dose								
			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 PRN	Max Dose/24hr	Dose								
			Sign								
Pharmacy	Indication		Date								
			Time								
Prescriber Signature	Print your name	Prescriber No.	Dose								
			Sign								

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

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ALLERGIES & ADVERSE REACTIONS (ADR)

☐ **Nil Known**

Drug (or other)	Reaction/Date	Initials

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

MEDICATIONS CEASED IN HOSPITAL- These medications have been ceased; please do not take without further medical advice.

Medication (print generic name)		Date Ceased (if known)	Reason (if known)
Medication	Dose		
Medication	Dose		
Medication	Dose		
Medication	Dose		
Medication	Dose		
Medication	Dose		
Medication	Dose		

MEDICATIONS WITHHELD IN HOSPITAL- These medications have been temporarily withheld

Medication (print generic name)		Plan on discharge
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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