LOGO

Medicine Prescription and Administration Record

NSV Code

Name of Trust

Record: _____ of _____

Rewritten on (date): _____

Allergies / Medicine Sensitivities

THIS SECTION MUST BE COMPLETED

Date	Medicine (generic) / allergen	Type or reaction e.g. rash	Signature
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

OR

No Known allergies ☐ Please tick

Signature: ..... **Date:** .....

Write in CAPITAL LETTERS or use addressograph

Surname: .....

First Names: .....

Hospital no: .....

DOB: .....

Check identity

Hospital: .....

Ward: .....

Consultant: .....

Date of admission: .....

Weight (Kg)	Height (cm)	Date

Requirements for Prescribing and Administration

THIS SECTION MAY BE USED TO HIGHLIGHT KEY POINTS FROM USE AND CONTROL OF MEDICINES, APRIL 2004

Special Instructions / Additional Notes on Medicines (please sign and date)

Once Only Medicines and Pre-medications
(includes administration under Patient Group Direction)

Patient Name:……………………………………………………………

Hospital Number:……………………………… **(complete if photocopying page)**

Prescription						Administration		
Date	Medicine	Dose	Route	Time to be given (24 hour clock)	Signature	Given by	Time given (24 hour clock)	Pharmacy

CODES FOR RECORDING OMITTED DOSES

N	= Nil by mouth	V	= Vomiting
R	= Patient refused	D	= Drug not available
P	= Patient not available	DR	= Prescribed omission
S	= Unable to swallow	O	= Other

Write in CAPITAL LETTERS or use addressograph

Surname: ....

First Names: ....

Hospital no: ....

DOB: ....

Check identity

REGULAR NON-INJECTABLE MEDICINES

Check for allergies / medicine sensitivities

Year:	**Day and month:** →														
Circle times or enter variable times and circle ↓	↓														

					Time
Medicine					02^{00}
Dose	Route	Start date	Stop date		06^{00}
Special instructions / Directions			Signature		10^{00}
					14^{00}
Signature	Print name		Pharmacy		18^{00}
Bleep					22^{00}

					Time
Medicine					02^{00}
Dose	Route	Start date	Stop date		06^{00}
Special instructions / Directions			Signature		10^{00}
					14^{00}
Signature	Print name		Pharmacy		18^{00}
Bleep					22^{00}

					Time
Medicine					02^{00}
Dose	Route	Start date	Stop date		06^{00}
Special instructions / Directions			Signature		10^{00}
					14^{00}
Signature	Print name		Pharmacy		18^{00}
Bleep					22^{00}

					Time
Medicine					02^{00}
Dose	Route	Start date	Stop date		06^{00}
Special instructions / Directions			Signature		10^{00}
					14^{00}
Signature	Print name		Pharmacy		18^{00}
Bleep					22^{00}

					Time
Medicine					02^{00}
Dose	Route	Start date	Stop date		06^{00}
Special instructions / Directions			Signature		10^{00}
					14^{00}
Signature	Print name		Pharmacy		18^{00}
Bleep					22^{00}

					Time
Medicine					02^{00}
Dose	Route	Start date	Stop date		06^{00}
Special instructions / Directions			Signature		10^{00}
					14^{00}
Signature	Print name		Pharmacy		18^{00}
Bleep					22^{00}

REGULAR NON-INJECTABLE MEDICINES

Check for allergies / medicine sensitivities

Patient Name:...

Hospital Number:..................................... (complete if photocopying page)

Year: | **Day and month:** →

Circle times or enter variable times and circle ↓

Medicine
Dose | Route | Start date | Stop date
Special instructions / Directions | Signature
Signature | Print name | Pharmacy
Bleep
02^{00} 06^{00} 10^{00} 14^{00} 18^{00} 22^{00}

Medicine
Dose | Route | Start date | Stop date
Special instructions / Directions | Signature
Signature | Print name | Pharmacy
Bleep
02^{00} 06^{00} 10^{00} 14^{00} 18^{00} 22^{00}

Medicine
Dose | Route | Start date | Stop date
Special instructions / Directions | Signature
Signature | Print name | Pharmacy
Bleep
02^{00} 06^{00} 10^{00} 14^{00} 18^{00} 22^{00}

Medicine
Dose | Route | Start date | Stop date
Special instructions / Directions | Signature
Signature | Print name | Pharmacy
Bleep
02^{00} 06^{00} 10^{00} 14^{00} 18^{00} 22^{00}

Medicine
Dose | Route | Start date | Stop date
Special instructions / Directions | Signature
Signature | Print name | Pharmacy
Bleep
02^{00} 06^{00} 10^{00} 14^{00} 18^{00} 22^{00}

Medicine
Dose | Route | Start date | Stop date
Special instructions / Directions | Signature
Signature | Print name | Pharmacy
Bleep
02^{00} 06^{00} 10^{00} 14^{00} 18^{00} 22^{00}

Medicine
Dose | Route | Start date | Stop date
Special instructions / Directions | Signature
Signature | Print name | Pharmacy
Bleep
02^{00} 06^{00} 10^{00} 14^{00} 18^{00} 22^{00}

CODES FOR RECORDING OMITTED DOSES

(N)	= Nil by mouth	(V)	= Vomiting
(R)	= Patient refused	(D)	= Drug not available
(P)	= Patient not available	(DR)	= Prescribed omission
(S)	= Unable to swallow	(O)	= Other

Write in CAPITAL LETTERS or use addressograph

Surname: ....

First Names: ....

Hospital no: ....

DOB: ....

Check identity

REGULAR NON-INJECTABLE MEDICINES

Check for allergies / medicine sensitivities

Year:	**Day and month:** →																
Circle times or enter variable times and circle ↓ ↓																	
Medicine		02^{00}															
Dose / Route / Start date	Stop date	06^{00}															
Special instructions / Directions	Signature	10^{00}															
		14^{00}															
Signature / Print name	Pharmacy	18^{00}															
Bleep		22^{00}															
Medicine		02^{00}															
Dose / Route / Start date	Stop date	06^{00}															
Special instructions / Directions	Signature	10^{00}															
		14^{00}															
Signature / Print name	Pharmacy	18^{00}															
Bleep		22^{00}															
Medicine		02^{00}															
Dose / Route / Start date	Stop date	06^{00}															
Special instructions / Directions	Signature	10^{00}															
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Signature / Print name	Pharmacy	18^{00}															
Bleep		22^{00}															
Medicine		02^{00}															
Dose / Route / Start date	Stop date	06^{00}															
Special instructions / Directions	Signature	10^{00}															
		14^{00}															
Signature / Print name	Pharmacy	18^{00}															
Bleep		22^{00}															
Medicine		02^{00}															
Dose / Route / Start date	Stop date	06^{00}															
Special instructions / Directions	Signature	10^{00}															
		14^{00}															
Signature / Print name	Pharmacy	18^{00}															
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Medicine		02^{00}															
Dose / Route / Start date	Stop date	06^{00}															
Special instructions / Directions	Signature	10^{00}															
		14^{00}															
Signature / Print name	Pharmacy	18^{00}															
Bleep		22^{00}															

REGULAR INJECTABLE MEDICINES

Check for allergies / medicine sensitivities

Patient Name:..

Hospital Number:.................................... (complete if photocopying page)

Year: | **Day and month:** →

Circle times or enter variable times and circle

Medicine

Dose	Route	Start date	Stop date

Special instructions / Directions | Signature

Signature | Print name | Pharmacy

Bleep

Time															
02^{00}															
06^{00}															
10^{00}															
14^{00}															
18^{00}															
22^{00}															

Medicine

Dose	Route	Start date	Stop date

Special instructions / Directions | Signature

Signature | Print name | Pharmacy

Bleep

Time															
02^{00}															
06^{00}															
10^{00}															
14^{00}															
18^{00}															
22^{00}															

Medicine

Dose	Route	Start date	Stop date

Special instructions / Directions | Signature

Signature | Print name | Pharmacy

Bleep

Time															
02^{00}															
06^{00}															
10^{00}															
14^{00}															
18^{00}															
22^{00}															

Medicine

Dose	Route	Start date	Stop date

Special instructions / Directions | Signature

Signature | Print name | Pharmacy

Bleep

Time															
02^{00}															
06^{00}															
10^{00}															
14^{00}															
18^{00}															
22^{00}															

Medicine

Dose	Route	Start date	Stop date

Special instructions / Directions | Signature

Signature | Print name | Pharmacy

Bleep

Time															
02^{00}															
06^{00}															
10^{00}															
14^{00}															
18^{00}															
22^{00}															

Medicine

Dose	Route	Start date	Stop date

Special instructions / Directions | Signature

Signature | Print name | Pharmacy

Bleep

Time															
02^{00}															
06^{00}															
10^{00}															
14^{00}															
18^{00}															
22^{00}															

Medicine

Dose	Route	Start date	Stop date

Special instructions / Directions | Signature

Signature | Print name | Pharmacy

Bleep

Time															
02^{00}															
06^{00}															
10^{00}															
14^{00}															
18^{00}															
22^{00}															

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- (O) = Other

Write in CAPITAL LETTERS or use addressograph

Surname: ....

First Names: ....

Hospital no: ....

DOB: ....

Check identity

REGULAR INJECTABLE MEDICINES

Check for allergies / medicine sensitivities

Year:	Day and month: →														
Circle times or enter variable times and circle	▼														
Medicine	02^{00}														
Dose / Route / Start date / Stop date	06^{00}														
	10^{00}														
Special instructions / Directions / Signature	14^{00}														
Signature / Print name / Pharmacy	18^{00}														
Bleep	22^{00}														
Medicine	02^{00}														
Dose / Route / Start date / Stop date	06^{00}														
	10^{00}														
Special instructions / Directions / Signature	14^{00}														
Signature / Print name / Pharmacy	18^{00}														
Bleep	22^{00}														
Medicine	02^{00}														
Dose / Route / Start date / Stop date	06^{00}														
	10^{00}														
Special instructions / Directions / Signature	14^{00}														
Signature / Print name / Pharmacy	18^{00}														
Bleep	22^{00}														
Medicine	02^{00}														
Dose / Route / Start date / Stop date	06^{00}														
	10^{00}														
Special instructions / Directions / Signature	14^{00}														
Signature / Print name / Pharmacy	18^{00}														
Bleep	22^{00}														
Medicine	02^{00}														
Dose / Route / Start date / Stop date	06^{00}														
	10^{00}														
Special instructions / Directions / Signature	14^{00}														
Signature / Print name / Pharmacy	18^{00}														
Bleep	22^{00}														
Medicine	02^{00}														
Dose / Route / Start date / Stop date	06^{00}														
	10^{00}														
Special instructions / Directions / Signature	14^{00}														
Signature / Print name / Pharmacy	18^{00}														
Bleep	22^{00}														

Write in CAPITAL LETTERS or use addressograph

Surname: ………………………………………………….

First Names: …………………………………………….

Hospital no: ……………………………………………

DOB: ……………………………………………………….

Check identity

AS REQUIRED MEDICINES

Check for allergies / medicine sensitivities

Medicine			Start Date	Date														
Dose	Route	Freq. (max)	Stop Date	Time														
Special Instructions / Directions			Signature	Dose / Route														
Signature	Print Name Bleep		Pharmacy	Given by														
Medicine			Start Date	Date														
Dose	Route	Freq. (max)	Stop Date	Time														
Special Instructions / Directions			Signature	Dose / Route														
Signature	Print Name Bleep		Pharmacy	Given by														
Medicine			Start Date	Date														
Dose	Route	Freq. (max)	Stop Date	Time														
Special Instructions / Directions			Signature	Dose / Route														
Signature	Print Name Bleep		Pharmacy	Given by														
Medicine			Start Date	Date														
Dose	Route	Freq. (max)	Stop Date	Time														
Special Instructions / Directions			Signature	Dose / Route														
Signature	Print Name Bleep		Pharmacy	Given by														
Medicine			Start Date	Date														
Dose	Route	Freq. (max)	Stop Date	Time														
Special Instructions / Directions			Signature	Dose / Route														
Signature	Print Name Bleep		Pharmacy	Given by														
Medicine			Start Date	Date														
Dose	Route	Freq. (max)	Stop Date	Time														
Special Instructions / Directions			Signature	Dose / Route														
Signature	Print Name Bleep		Pharmacy	Given by														
Medicine			Start Date	Date														
Dose	Route	Freq. (max)	Stop Date	Time														
Special Instructions / Directions			Signature	Dose / Route														
Signature	Print Name Bleep		Pharmacy	Given by														