	бı	Pharm & Supply notes									
	onitorir <b>sa)</b>	Time stopped									
	and m ( <b>Medu</b> ) ) 7067	Time started									
	ompatibilities aicines aicines Guide 13) 3785 / (14)	Given by 2nd Check									
	ns rates, c able Med rmation (	Batch no.									
	For information on dilutions, infusions rates, compatibilities and monitoring parameters, consult the Injectable Medicines Guide (Medusa) or contact Medicines Information (13) 3785 / (14) 7067	Prescriber signature & bleep									
	nformation or parameters, or conta	Route and line									
10		Duration									
Infusions	Mi	Rate									
		Additives and dose									
ıber		Volume									
Patient Name & Hospital Number		Solution									
Patien		Date									

Medication O	rder and Adm	inistratio	n Char	t Fast	Sussex Health	ncare \(\lambda\)	IHS
Allergies,	Adverse Effect Consideration		er	Last		HS Trust	
Drug / Food / Other Det	tails	Sign / Date Designation		Ward	Consultant	Admiss	ion Date
					Patient Det Please attach addresse		
				Surname	First Na	ame	
				Hospital Number	NHS N	umber	
Height (M) BSA (M²)	Weight (Kg)  Date Weighed	ВМІ		Address			Date of Birth / Age
Chart number	of						
Chamatharany					ck / specify)	Othor	
	ringe Driver Transf		gations	TPN:	Other:	Other:	
	conciliation and	d Manager		Notes	(pr	narmacy us	se only)
Accurate		Review Ne					
Date	eview Notes (p Problem / reason for rev		s to rev Reported by	Seen by	ction as appropri		Date
Time							
	ıg Discharge P						
Medicine	Strength Forr	n Dose	Freq	l otal qua	ntity (words and figures)	Signature	Date
Pharmacy supply notes:						TTA screen	

Reco	ord of	Omitted and Dela	yed Doses			
ate	Time	Medicine	Reason	Nurses signature	Action taken	Follow-up
atie	nt Sel	f Administration	of Medicines Asses	ssment Log		
		res for Patient Self-Adminis			Comm	ents / Concerns

Hospital Number

Patient Name

Patie	nt Self	Adm	ninis	trati	on o	f Me	dici	nes	Ass	essn	nent	Log			
Refer to	Procedure	s for Pa	atient S	Self-Adr	ministra	ation of	Medic	cines							Comments / Concerns
Level 1	Nurse ad	ministr	ation	Re-as	sess le	evel wh	en inc	licated	I						
Level 2	Supervise			Asked Open Took											
Level 3	Holds the key to the medicines locker and it is kept in a secure place														
Date	Tells staff when he/she has taken PRN medicines														
Time	ime IIII														
Assesse	essed Level														
Initials															

Patient Name	е							Н	ospital	Numb	er								
As Requ	ired		Date	Time	Dose	Route	Sig	Date	Time	Dose	Route	Sig		Date	Time	Dose	Route	Sig	
Medicine													╟						Pharm
							Н						╟						Oversto
Dose	Route(s)	Frequency											lŀ						Supply
Indication	N h	Max dose in 24 ours																	Duration (days)
Special instruction	ns																		
		<u> </u>					Ш												GP to review
Signature & blee	р	Date					Ш												TTA
Mandiala -																			TTA
Medicine							Ш												Pharm
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TTA sign

TTA Date

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Patient Nam	е							Н	ospital	Numb	er								
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Dose 3-10ml	Route IV	Special instruction REFER TO UMEN	<b>PVAD</b>																
	PRE	AND POST																	
IV MEDICATION Signature & bleep Date  As Required Medicine		Date																	
As Required  Medicine  Route(s) Free			Date	Time	Dose	Route	Sig	Date	Time	Dose	Route	Sig	Date	Time	Dose	Rout	e Sig	1	<u> </u>
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Medicine  Dose Route(s) Frequency Indication Max dose		Frequency																Su	pply
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atient Name		Hospi	tal N	umbe	er									
Oxygen Prescriptions														
arget oxygen saturation	Da	ite												
38 - 93%	Time													
Continuous ☐ Review every 24 hours PRN ☐	Mornin	ng												
umidify if over 24 hours	Midda	y												
ow rate / concentration (specify range)	Evenir	ng												
oxygen saturation outside of target range	Bedtim	ne												
escriber's signature & bleep Date														
38 - 93%	Time Da	ate												
Continuous  Review every 24 hours PRN	Mornin	ng												
umidify if over 24 hours	Midday	y												
ow rate / concentration (specify range)	Evenir	ng												
oxygen saturation outside of target range	Bedtim	ne												
escriber's signature & bleep Date														
lil by Mouth - Surgery														
nsure that all regular prescribed medicines ave been taken with 30ml of water on the ay of surgery.  Exceptions  1. Where conditions are the conditions are that all regular prescribed medicines are the conditions.	learly											and	insu	ılin
Once Only and Pre-anaesthetic Medicatio	n													
ate Time to be given Medicine (approved name) Route	Dose	e		escri gnatu				Date given	Give by	en	Time giver		Phar	m
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<del>- 1 - 1</del>			_				-					-		

Once	Only ar	nd Pre-anaesthetic Med	lication						
Date	Time to be given	Medicine (approved name)	Route	Dose	Prescriber's signature	Date given	Given by	Time given	Pharm

Patient Name Hospital Number

1. Never use abbreviations e.g. 'U' or 'IU'. Include administration method (e.g. Flexpen, Solostar, cartridges, vials) in special instructions. To change the dose, cross through & rewrite all daily doses. IV Insulin should be prescribed on the separate IV Insulin medication order and administration chart.

- 2. Patients self-administering insulins should be assessed daily and this should be documented on page 2.
- 3. **ALWAYS** use FULL correct name and proprietary name of the insulin.
- 4. **ALWAYS** give rapid acting analogues (Humalog, Apidra, Novorapid), short acting human insulin (Humulin S, Human Actrapid), and human biphasic (Humulin M3) and analogue biphasic (Novomix 30, Humalog Mix 25 or Humalog Mix 50) with meals.
- 5. **ALWAYS** give Insulin Glargine (Lantus) & Insulin Detemir (Levemir) or other BASAL insulin at the same time each day, irrespective of meals and even if the patient is receiving intravenous insulin.
- 6. For further advice contact the diabetes team.

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Once	Only S	ubcutaneous Insulin Pi	rescrip	tions					
Date	Time to be given	Insulin (approved name)	Route	Dose	Prescriber's signature	Date given	Given by	Time given	Pharm

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Regu	ılar Sı	ubcuta	neou	s Insu	ılin Pres	crip	tion	S					Мо	nth			Yea	ar	4
Date	Date	Date	Date	Date	Insulin (approve	d name)							Supply	1			For TT	A	
Route S/C	Route S/C	Route S/C	Route S/C	Route S/C	1												GP to r	eview	
Start Dose	1st change	2nd change	3rd change	4th change	Date Date													747	
Units	s Units	s Units	s Units	s Units	Breakfast													5	
Units	s Units	s Units	s Units	s Units	Lunch													٥),	
Units	s Units	s Units	s Units	s Units	Evening Meal												200		
Units	s Units	s Units	s Units	s Units	Bedtime														
Sign	Sign	Sign	Sign	Sign	Special Instruction	ons													
Date	Date	Date	Date	Date	Insulin (approve	ed name)							Supply	<i>'</i>			For TT	A	
Route S/C	Route S/C	Route S/C	Route S/C	Route S/C													GP to r	review	Γ
<u> </u>	1						Г					T		T		T		$\overline{}$	-

Date	Date	Date	Date	Date	Insulin (approved	name	)			Supply		For TT.	A	
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Start Dose	1st change	2nd change	3rd change	4th change	Date								77	,
Units	Units	Units	Units	Units	Breakfast								90	
Units	Units	Units	Units	Units	Lunch								٥,,	
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Units	Units	Units	Units	Units	Bedtime			1						
Sign	Sign	Sign	Sign	Sign	Special Instruction	ns								

Date	Date	Date	Date	Date	Insulin (approve	d name)				Supply		For TT	A	
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Units	Units	Units	Units	Units	Bedtime									
Sign	Sign	Sign	Sign	Sign	Special Instruction	ons								

Patient Name Hospital Number

NB: An antimicrobial prescription must contain a duration or review date [in special instructions], and indication

When a chart is rewritten the original date of starting treatment must be noted

	W	hen	a ch	art is	rewr	itten	the o	rigina	l date	of st	arting	g trea	tmen	t mus	st be i	noted			
Enter dose a				Re	gula	r Me	dici	nes		Моі	nth				Yea	ar			
required. Use only for each		ite [	Date															Planning	
Date		T .		Medici	ne (appi	roved na	me)	<u> </u>		Start D	ate	<u> </u>	Prescri	ber sign	(original)	)	Phar	Special instruc	tions
Route				İ						Duratio	n (days)	)			bleep				
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(if required)	Dose	Cha	inge				·	r						_	bleep			 	
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				ΙXΡ	rescrit	oer ren	uest :	S Self-	I admin	istered	1 Re	efused		2 N	BM / v	omitina	1 <u> </u>	TTA sign	
Reasons for no Apart from 'pres 'self administere	criber reque	est' a	nd	<b>X</b> P	rescrit	er req	uest	S Self-	admin	istered	<b>1</b> Re	efused	<u> </u>		BM / v			TTA sign	

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taken must be documented on page 2 3 Withheld

Patient Name Hospital Number

NB: All Intravenous Medicines should be reviewed after 48 hours and as condition changes Units, micrograms and nanograms must be written in full

Enter dose a	gainst tin	ne	Red	alur	r Me	edici	nes		Мо	nth				Yea	ar			
required. Use	e one rou	te Date						<u> </u>	1010	Γ		1	1		<u></u>	1	Planning	
only for each	entry	<b>→</b>	Medici	ne (appr	oved na	me)			Start D	ate		Prescri	ber sign	(original)		Phar	Special instruc	
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Midday  Evening  Bedtime			Medicin	ne (appr	oved name	me)			١ ١			Prescri	_	(original)		Phar	GP to review Supply	ctions
Midday  Evening  Bedtime  Date  Route		Dage	Medici	ne (appr	roved nai	me)			Duratio	n (days)			_	bleep		Phar	GP to review Supply	ctions
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Midday  Evening  Bedtime  Date  Route  Time (if required)  Morning  Midday	Dose		Medici	ne (appr	oved nar	me)			Duratio	n (days)			ber sign	bleep (change			GP to review Supply Special instruct	ctions
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Patient Name Hospital Number

This section is intended for prescribing medicines that could change as a consequence of monitoring parameters such as serum levels, dose changes or titrations and include:

- 1. Vancomycin and gentamicin
- 2. Coumarin anticoagulants i.e. warfarin, phenindione, acenocoumarol
- 3. Unfractionated heparin
- 4. Reducing doses of steroids

						g doses of			
<b>Complex</b>	and V	/ariable Dose N	ledicine	es					
Medicine (approved r	name)		Date	Time	Observation / level	Dose	Prescriber's Signature	Given by	Time given
Dose and instructions (specify monitoring value)	s ariables, fre	equency or any protocol)							
Indication		Target observation / level							
Route		Target range							
Duration (days)									
Prescriber's signature	e								
Date		Pharmacist							
For TTA		Supply							
GP to review									
	name)		Date	Time	Observation / level	Dose	Prescriber's Signature	Given by	Time given
	name)		Date	Time	Observation / level	Dose	Prescriber's Signature	Given by	Time given
Medicine (approved r	s	equency or any protocol)	Date	Time	Observation / level	Dose	Prescriber's Signature	Given by	
Medicine (approved r	s	equency or any protocol)	Date	Time	Observation / level	Dose	Prescriber's Signature	Given by	
Medicine (approved r	s	equency or any protocol)	Date	Time	Observation / level	Dose	Prescriber's Signature	Given by	
Medicine (approved r	s	equency or any protocol)	Date	Time	Observation / level	Dose	Prescriber's Signature	Given by	
Medicine (approved r	s	equency or any protocol)	Date	Time	Observation / level	Dose	Prescriber's Signature	Given by	
Medicine (approved r	s	equency or any protocol)	Date	Time	Observation / level	Dose	Prescriber's Signature	Given by	
Medicine (approved of a contraction of a	s		Date	Time	Observation / level	Dose	Prescriber's Signature	Given by	
Medicine (approved of a contraction of a	s	equency or any protocol)  Target observation / level	Date	Time	Observation / level	Dose	Prescriber's Signature	Given by	
Medicine (approved of a contraction of a	s	Target observation / level	Date	Time	Observation / level	Dose	Prescriber's Signature	Given by	
Medicine (approved of a contraction of a	s		Date	Time	Observation / level	Dose	Prescriber's Signature	Given by	
Medicine (approved of a contraction of a	s ariables, fro	Target observation / level	Date	Time	Observation / level	Dose	Prescriber's Signature	Given by	
Medicine (approved of a contraction of a	s ariables, fro	Target observation / level	Date	Time	Observation / level	Dose	Prescriber's Signature	Given by	
Medicine (approved of a continuous continuou	s ariables, fro	Target observation / level Target range	Date	Time	Observation / level	Dose	Prescriber's Signature	Given by	
Medicine (approved r	s ariables, fro	Target observation / level  Target range  Pharmacist	Date	Time	Observation / level	Dose	Prescriber's Signature	Given by	
Medicine (approved of a continuous continuou	s ariables, fro	Target observation / level Target range	Date	Time	Observation / level	Dose	Prescriber's Signature	Given by	

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Patient Name				Hospital Nun	nber			
Complex and	Variable Dose I	Medicine	es					
Medicine (approved name)		Date	Time	Observation / level	Dose	Prescriber's Signature	Given by	Time given
Dose and instructions (specify monitoring variables	s, frequency or any protocol)							
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Route	Target range						+	<del>                                     </del>
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1 rescriber 9 signature							<del>                                     </del>	
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Date	Pharmacist							
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GP to review								
Medicine (approved name)		Date	Time	Observation / level	Dose	Prescriber's Signature	Given by	Time given
						Signature		giveii
Dose and instructions (specify monitoring variables	s, frequency or any protocol)							
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Date	Pharmacist							
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MOACv1.0 J. Palmer DEC 2013

Patient Name Hospital Number

NB: An antimicrobial prescription must contain a duration or review date [in special instructions], and indication
When a chart is rewritten the original date of starting treatment must be noted

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MOACv1.0 J. Palmer DEC 2013

MOACv1.0 J. Palmer DEC 2013

Hospital Number

NB: All Intravenous Medicines should be reviewed after 48 hours and as condition changes Units, micrograms and nanograms must be written in full

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Patient Name Hospital Number

NB: An antimicrobial prescription must contain a duration or review date [in special instructions], and indication When a chart is rewritten the original date of starting treatment must be noted

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NB: All Intravenous Medicines should be reviewed after 48 hours and as condition changes Units, micrograms and nanograms must be written in full

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Patient Name Hospital Number

NB: An antimicrobial prescription must contain a duration or review date [in special instructions], and indication When a chart is rewritten the original date of starting treatment must be noted

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