Patient name ______________________________ DOB ______________ CHI ____________________

AS REQUIRED THERAPY

Medicine/Form	
Dose	Route
Frequency & Indication	MAX Dose in 24hrs
Signature/Print name	Start Date
Pharmacy	Additional Instructions

Date								
Time								
Dose								
Initials								
Date								
Time								
Dose								
Initials								

Medicine/Form	
Dose	Route
Frequency & Indication	MAX Dose in 24hrs
Signature/Print name	Start Date
Pharmacy	Additional Instructions

Date								
Time								
Dose								
Initials								
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Dose								
Initials								

Medicine/Form	
Dose	Route
Frequency & Indication	MAX Dose in 24hrs
Signature/Print name	Start Date
Pharmacy	Additional Instructions

Date								
Time								
Dose								
Initials								
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Initials								

Medicine/Form	
Dose	Route
Frequency & Indication	MAX Dose in 24hrs
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Time								
Dose								
Initials								
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Medicine/Form	
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Frequency & Indication	MAX Dose in 24hrs
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Date								
Time								
Dose								
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Patient name ______________________ DOB ____________ CHI ______________

AS REQUIRED THERAPY

Medicine/Form	
Dose	Route
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Date								
Time								
Dose								
Initials								
Date								
Time								
Dose								
Initials								

NHS Grampian

PRESCRIPTION & ADMINISTRATION RECORD

Patient Name: CHI number: Date of Birth: (Attach printed label here)	Date of admission _____ Prescription number _____ Date re-written _____	
Hospital / Ward:	Weight: kg	Height:
Consultant:	Date recorded:	Gender: M / F

KNOWN MEDICINE ALLERGIES/SENSITIVITIES (if NONE confirmed write NKDA in Box 1)			
Must be documented before prescription/administration except in exceptional circumstances			
1.	2.	3.	4.

VENOUS THROMBOEMBOLISM RISK ASSESSMENT HAS BEEN UNDERTAKEN ON ADMISSION sign _____

OTHER MEDICINE CHARTS OR TREATMENT PLANS IN USE (Please tick)					
CHART TYPE		CHART TYPE		CHART TYPE	
1. Diabetes prescription sheet		5. Anaesthetic Record		9. Mental Health Care and Treatment (Scotland) Act 2003 - T2/T3 form	
2. Intravenous Patient-controlled analgesia prescription sheet		6. Oral anticoagulant prescription sheet		10. Adults with Incapacity (Scotland) Act 2000. (Section 47 Certificate and Treatment Plan)	
3. Fluid (additive medicine) prescription and recording sheet		7. Dermatology sheet		11. Syringe Driver	
4. Chemotherapy prescription sheet		8. Ophthalmology sheet		12. Other	

ONCE ONLY PRESCRIPTIONS

Date	Time	Medicine	Dose	Route	Prescribed By (signature / print name)	Time Given	Given By

NOTES FOR USERS

Prescribing medication:

1. Sign your name clearly against each prescription.
2. When medicines are discontinued, draw a single diagonal line through the medicine prescribed section, a single vertical line through the rest of that day's administration boxes and a double diagonal line through the remaining boxes on the administration section for that medicine. The authorised prescriber must then sign and date under this double line.
3. If an existing prescription is to be modified, delete existing prescription and re-write new instructions in a new section.
4. Use approved names in BLOCK LETTERS and use metric doses as follows:
   Milligram = mg Gram = g Millilitre = mL Microgram = to be written in full
   Fractions of a milligram should be written in micrograms. A zero should be written in front of a decimal point where there is no other figure, e.g. 0.5mL **not** .5mL
5. Method of administration should be abbreviated as follows:

Oral	**= ORAL (must be written in full 'O' is not acceptable)**						
Sublingual	**= SL**	**Subcutaneous**	**= SC**	**Intramuscular**	**= IM**	**Intravenous**	**= IV**
Intradermal	**= ID**	**Inhalation**	**= INH**	**Nebulised**	**= NEB**	**Topical**	**= TOP**
Rectal	**= PR**	**Vaginal**	**= PV**	**Gastrostomy**	**= Gastros**	**Nasogastric**	**= NG**
Orogastric	**= OG**	**Jejunostomy**	**= Jej**	**Nasojejunostomy**	**= NJ**	**Buccal**	**= Buccal**

Recording administration:

1. The 'Regular' and 'As Required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.
2. Ensure entry is made on administration record each time medicine is given. Initial in relevant date column and time row.
3. Check that all medicines prescribed at a certain time are administered.
4. If medicine is not administered, enter reason in appropriate box using the coding system.
5. If administered more than 1 hour outwith time prescribed, enter time in administration box.

CODES FOR NON-ADMINISTRATION OF PRESCRIBED MEDICINES

If a dose is not administered, initial and enter the appropriate code in the administration box with a circle drawn round it:

1. Patient refused
2. Patient unavailable
3. Medicine out of stock
4. Instructions not clear/legal
5. Nil by mouth
6. Once only/as required
7. Dose withheld - Prescriber's instructions
8. Self administered by patient
9. Nausea/vomiting
10. Unable to swallow
11. No intravenous access
12. Anaesthetist requested omission
13. Other.....
14. Other.....
15. Other.....
16. Other.....

General Comments:

MEDICINES CARE PLAN

Patient name _____ CHI _____

Presenting Complaint:	PMH:

	Tick	Details
Patient's own medicines checked		
Medicines reconciled		
Compliance Aid?		
Resident in Care Home		
Level 3 medicines management at home?		

CARE ISSUES	Action / Outcome	Initials	Date

Patient name ______________________ DOB ____________ CHI ____________

REGULAR THERAPY	Date → / Time ↓
Medicine/Form	08
Dose / Route	12
Signature/Print name	14
Pharmacy / Start Date / Frequency	18
Additional Instructions	20
	22
Medicine/Form	08
Dose / Route	12
Signature/Print name	14
Pharmacy / Start Date / Frequency	18
Additional Instructions	20
	22
Medicine/Form	08
Dose / Route	12
Signature/Print name	14
Pharmacy / Start Date / Frequency	18
Additional Instructions	20
	22
Medicine/Form	08
Dose / Route	12
Signature/Print name	14
Pharmacy / Start Date / Frequency	18
Additional Instructions	20
	22
Medicine/Form	08
Dose / Route	12
Signature/Print name	14
Pharmacy / Start Date / Frequency	18
Additional Instructions	20
	22

ENTRIES MUST BE RE-WRITTEN BEFORE FURTHER DOSES ARE ADMINISTERED

Patient name ______________________ DOB ____________ CHI ____________

REGULAR THERAPY	Date → / Time ↓																	
Medicine/Form	08																	
Dose / Route	12																	
Signature/Print name	14																	
Pharmacy / Start Date / Frequency	18																	
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Patient name ______________________ DOB ____________ CHI ____________

REGULAR THERAPY

Medicine details	Date → / Time ↓																		
Medicine/Form	08																		
Dose / Route	12																		
Signature/Print name	14																		
Pharmacy / Start Date / Frequency	18																		
Additional Instructions	20																		
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