Attach ADR Sticker

ALLERGIES & ADVERSE REACTIONS (ADR)

☐ Nil known ☐ Unknown (tick appropriate box or complete details below)

Drug (or other)	Reaction/Date	Initials

Sign ..... Print ..... Date .....

AFFIX PATIENT IDENTIFICATION LABEL HERE & OVERLEAF

UR No:

Family Name:

Given Names:

Address:

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

DOB: **Sex** ☐ **M** ☐ **F**

1st Prescriber to Print Patient Name and Check Label Correct: .....

Patient Weight (kg) .....

Height (cm) .....

Health Service Logo

Hospital: _____

Ward/Unit: _____

Consultant: _____

VARIABLE DOSE Chart No. _____ **of** _____

MEDICATIONS WITH VARIABLE DOSAGE

Medication (Print Generic Name)

Route | Indication/Directions

Desired Result | Pharmacy Use

Date	Time of Dose	Dose	Drug Level /Result	Time Level Taken	Prescriber		Nurse/Midwife Initials		Time Given	Clinical Pharmacist Review
					Name	Signature	1st	2nd		

This medication continued on new chart **Yes** ☐ **No** ☐ NIMC No. _____ **OR** Variable Dose Chart No. _____

Medication (Print Generic Name)

Route | Indication/Directions

Desired Result | Pharmacy Use

Date	Time of Dose	Dose	Drug Level /Result	Time Level Taken	Prescriber		Nurse/Midwife Initials		Time Given	Clinical Pharmacist Review
					Name	Signature	1st	2nd		

This medication continued on new chart **Yes** ☐ **No** ☐ NIMC No. _____ **OR** Variable Dose Chart No. _____

VARIABLE DOSE CHART

MEDICATIONS WITH VARIABLE DOSAGE

Attach ADR Sticker

See front page for details

Year 20___

AFFIX PATIENT IDENTIFICATION LABEL HERE & OVERLEAF

UR No:

Family Name:

Given Names:

Address:

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

DOB: **Sex** ☐ **M** ☐ **F**

1st Prescriber to Print Patient Name and Check Label Correct:.....

MEDICATIONS WITH VARIABLE DOSAGE

Medication (Print Generic Name)

Route | Indication/Directions

Desired Result | Pharmacy Use

Date	Time of Dose	Dose	Drug Level /Result	Time Level Taken	Prescriber		Nurse/Midwife Initials		Time Given	Clinical Pharmacist Review
					Name	Signature	1st	2nd		

This medication continued on new chart **Yes** ☐ **No** ☐ NIMC No. _____ **OR** Variable Dose Chart No. _____

Medication (Print Generic Name)

Route | Indication/Directions

Desired Result | Pharmacy Use

Date	Time of Dose	Dose	Drug Level /Result	Time Level Taken	Prescriber		Nurse/Midwife Initials		Time Given	Clinical Pharmacist Review
					Name	Signature	1st	2nd		

This medication continued on new chart **Yes** ☐ **No** ☐ NIMC No. _____ **OR** Variable Dose Chart No. _____