8 Day National Medication Chart

Chart ______ of ______

Date Recharted ____________
Day Month Year

First prescriber to write patient's name and NHI:

____

Family Name: ______________________________

Given Name: ____________________ Gender: ________

AFFIX PATIENT LABEL HERE

Date of Birth: ________________ NHI#: ______________

Special Care Required	Supplementary Medicine Charts
☐ Renal impairment	☐ Insulin
☐ Hepatic impairment	☐ Specialised analgesia
☐ Pregnancy	☐ Heparin
☐ Breastfeeding	☐ Warfarin
☐ Anticoagulation	☐ Other ____________
☐ Other ____________	☐ Other ____________

Admission Medicine Reconciliation	
☐ Discrepancies identified **Signature**	**Date**
☐ Discrepancies reconciled **Signature**	**Date**
☐ No discrepancies identified **Signature**	**Date**

Sample signatures – Prescribers

Name & Reg No. (family & given)	Signature	Contact No.

Sample initials – Administrators/Others

Name & Reg No. (family & given)	Initials	Name & Reg No. (family & given)	Initials

DO NOT WRITE IN THIS AREA

NMC8D February 2020

Weight (kg)	Date
Weight (kg)	Date
Gestational age at birth (weeks)	
Height (cm)	Date
BSA (m²)	Date

Family Name:

Given Name: Gender:

AFFIX PATIENT LABEL HERE

Date of Birth: NHI#:

Allergies & Adverse Reactions

No ☐

Medication / other	Reaction	New this admission	Medication / other	Reaction	New this admission
		☐			☐
		☐			☐
		☐			☐
		☐			☐
		☐			☐

Signature **Date**

Once Only

Date	Medicine					Given by / Checked by
	Dose	Units	Route	Dose calculation (eg. mg/kg per dose)	Prescriber's signature	Date administered
			Date & time of dose		Pharmacy & special instructions / Pharm	Time commenced / Time completed

Date	Medicine					Given by / Checked by
	Dose	Units	Route	Dose calculation (eg. mg/kg per dose)	Prescriber's signature	Date administered
			Date & time of dose		Pharmacy & special instructions / Pharm	Time commenced / Time completed

Date	Medicine					Given by / Checked by
	Dose	Units	Route	Dose calculation (eg. mg/kg per dose)	Prescriber's signature	Date administered
			Date & time of dose		Pharmacy & special instructions / Pharm	Time commenced / Time completed

Date	Medicine					Given by / Checked by
	Dose	Units	Route	Dose calculation (eg. mg/kg per dose)	Prescriber's signature	Date administered
			Date & time of dose		Pharmacy & special instructions / Pharm	Time commenced / Time completed

Date	Medicine					Given by / Checked by
	Dose	Units	Route	Dose calculation (eg. mg/kg per dose)	Prescriber's signature	Date administered
			Date & time of dose		Pharmacy & special instructions / Pharm	Time commenced / Time completed

Date	Medicine					Given by / Checked by
	Dose	Units	Route	Dose calculation (eg. mg/kg per dose)	Prescriber's signature	Date administered
			Date & time of dose		Pharmacy & special instructions / Pharm	Time commenced / Time completed

Date	Medicine					Given by / Checked by
	Dose	Units	Route	Dose calculation (eg. mg/kg per dose)	Prescriber's signature	Date administered
			Date & time of dose		Pharmacy & special instructions / Pharm	Time commenced / Time completed

ONCE ONLY

DO NOT WRITE IN THIS AREA

DO NOT WRITE IN THIS AREA

Once Only

Date	Medicine					Given by / Checked by
	Dose	Units	Route	Dose calculation (eg. mg/kg per dose)	Prescriber's signature	Date administered
			Date & time of dose		Pharmacy & special instructions / Pharm	Time commenced / Time completed

Date	Medicine					Given by / Checked by
	Dose	Units	Route	Dose calculation (eg. mg/kg per dose)	Prescriber's signature	Date administered
			Date & time of dose		Pharmacy & special instructions / Pharm	Time commenced / Time completed

Verbal Orders (must be signed as soon as possible or within 24 hours of order)

Date & Time	Medicine							Given by / Checked by
	Dose	Units	Route	Dose calculation (eg. mg/kg per dose)	Date & time of dose	Initials: Nurse / Initials: Witness	Time commenced / Time completed	
			Prescriber's name		Prescriber's signature	Pharmacy & special instructions	Pharm	

Date & Time	Medicine							Given by / Checked by
	Dose	Units	Route	Dose calculation (eg. mg/kg per dose)	Date & time of dose	Initials: Nurse / Initials: Witness	Time commenced / Time completed	
			Prescriber's name		Prescriber's signature	Pharmacy & special instructions	Pharm	

Date & Time	Medicine							Given by / Checked by
	Dose	Units	Route	Dose calculation (eg. mg/kg per dose)	Date & time of dose	Initials: Nurse / Initials: Witness	Time commenced / Time completed	
			Prescriber's name		Prescriber's signature	Pharmacy & special instructions	Pharm	

Oxygen Therapy

Remember: to document oxygen administration on the patient's Vital Signs chart (L/minute)

Target oxygen saturation (%):	☐ 88-92% For most acutely unwell patients	☐ 92-96% For those at risk of hypercapnic failure	☐ Other ___________________

Start date	Device/delivery	Flow rate range / FiO_2	Signature	Stop date