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Attach ADR Sticker

**ALLERGIES & ADVERSE REACTIONS (ADR)**  
 Nil known     Unknown (tick appropriate box or complete details below)

Drug (or other)	Reaction/Type/Date	Initials

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

AFFIX PATIENT IDENTIFICATION LABEL HERE & OVER LEAF

UR No: \_\_\_\_\_  
 Family Name: \_\_\_\_\_  
 Given Names: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Sex  M  F  
 DOB: \_\_\_\_\_  
 Patient Weight (kg).....  
 Height (cm).....

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

**REGULAR MEDICATIONS**

YEAR 20 \_\_\_\_\_ DATE & MONTH \_\_\_\_\_

**VARIABLE DOSE MEDICATION**

Date	Medication (Print Generic Name)	Drug level	Time level taken	Dose	Time of Dose:	Prescriber	Pharmacy	Indication	Prescriber Signature	Print Your Name	Contact	Continue on discharge? Yes/No	Dispense? Yes/No	Duration? days/Qty?

**WARFARIN (Marevan/Coumadin) select brand**

DOSE TIME 1600 (4pm)

Date	Medication (Print Generic Name)	INR Result	Dose	Time of Dose:	Prescriber	Pharmacy	Indication	Prescriber Signature	Print Your Name	Contact	Continue on discharge? Yes/No	Dispense? Yes/No	Duration? days/Qty?

**DOCTORS MUST ENTER administration times**

Date	Medication (Print Generic Name)	Tick if Slow release	Route	Dose	Frequency & NOW enter times	Indication	Pharmacy	Prescriber Signature	Print Your Name	Contact	Continue on discharge? Yes/No	Dispense? Yes/No	Duration? days/Qty?

Pharmaceutical Review: \_\_\_\_\_

**RECOMMENDED ADMINISTRATION TIMES GUIDELINES ONLY**

Time	Code	0800	1200	1800	2000
Morning	Mane				
Night	Nocte				1800 or 2000
Twice a day	BD	0800	2000		
Three times a day	TDS	0800	1400	2000	
Regular 6 hourly	6 hrly	0600	1200	1800	2400
Regular 8 hourly	8 hrly	0600	1400	2200	
Four times a day	QID	0600	1200	1800	2200

**WARFARIN EDUCATION RECORD**

Patient Educated by: \_\_\_\_\_  
 Sign: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Given Warfarin Book: \_\_\_\_\_  
 Sign: \_\_\_\_\_  
 Date: \_\_\_\_\_

SR= Sustained or modified release formulation. If scored tablet, then half can be given. Dose must be swallowed without crushing.

**REASON FOR NURSE NOT ADMINISTERING Codes MUST be circled**

Absent	(A)
Fasting	(F)
Refused - notify Dr	(R)
Vomiting	(V)
On leave	(L)
Not available - obtain supply or contact Dr	(N)
Withheld - Enter reason in Clinical Record	(W)
Self Administering	(S)

**REGULAR MEDICATIONS**

YEAR 20 \_\_\_\_\_ DATE & MONTH \_\_\_\_\_

**DOCTORS MUST ENTER administration times**

Date	Medication (Print Generic Name)	Tick if Slow release	Route	Dose	Frequency & NOW enter times	Indication	Pharmacy	Prescriber Signature	Print Your Name	Contact	Continue on discharge? Yes/No	Dispense? Yes/No	Duration? days/Qty?

Pharmaceutical Review: \_\_\_\_\_