Inpatient Medication Administration Record __of___

Guy's and St Thomas' NHS
NHS Foundation Trust

Supplementary charts in use

		Start Date	Stop Date			Start Date	Stop Date
Anticoagulant	☐			Patient controlled analgesia/epidural	☐		
Blood Transfusion (Components and Products)	☐			Supplementary Infusion	☐		
Chemotherapy	☐			Syringe driver	☐		
Gentamicin	☐			Transdermal patch	☐		
Hemodialysis/ Peritoneal	☐			Vancomycin	☐		
IV Insulin	☐			Sub intravenous insulin	☐		
Nutrition	☐			Other (please specify)	☐		

Discharge Planning : Estimated Discharge Date...../...../.....

Patient discharge	Initial	Date	Advice to GP on the changes to therapy, monitoring required
TTO written Signed			
TTO checked			
TTO supplied			
Drug advice provided			
Possible adverse effects, and what to do explained			

Do Not Prescribe, Dispense or Administer if Drug Allergy Box is Not Completed

Once-Only Medication/Time Critical Doses

Date	Time to be given	Drug (approved name)	Dose	Route	Prescriber		Bleep No.	Date given	Time given	Given by	Pharm -acist
					Sign	Name					

Regular Medicines

Drug (Approved Name)		Dose	Route	New Dose/Route	New Dose/Route	Indication, Additional Info, Pharmacy
Date	Valid Period	Contact Details	GMC no.	Date	Date	
Prescriber's Signature		Print Name		Initials	Initials	
Drug (Approved Name)		Dose	Route	New Dose/Route	New Dose/Route	Indication, Additional Info, Pharmacy
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Pharmacist Check, Time

THIS AREA IS CUT AWAY IN ACTUAL BOOKLET

Administration Record

Tick or enter times required	Enter Date														
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As Required Medicines

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Intravenous & Subcutaneous Infusions.

Date	Time	Infusion Fluid		Additions to Infusions		IV, SC or CVC	Prescriber's Signature, name, GMC no.	Time & Date Started	Time to run or ml/hour	Fluid Batch No.	Given By	Checked By	Pharmacy
		Type/Strength	Volume	Drug	Dose								

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Intravenous & Subcutaneous Infusions.

Date	Time	Infusion Fluid		Additions to Infusions		IV, SC or CVC	Prescriber's Signature, name, GMC no.	Time & Date Started	Time to run or ml/hour	Fluid Batch No.	Given By	Checked By	Pharmacy
		Type/Strength	Volume	Drug	Dose								

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Date	Time	Infusion Fluid		Additions to Infusions		IV, SC or CVC	Prescriber's Signature, name, GMC no.	Time & Date Started	Time to run or ml/hour	Fluid Batch No.	Given By	Checked By	Pharmacy
		Type/Strength	Volume	Drug	Dose								

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Do Not Prescribe, Dispense or Administer if Drug Allergy Box is Not Completed

Surname		
Forename		
D.O.B.		
Hospital No:		
NHS No:		Sex M/F
Consultant	FY Name	FY bleep
Weight	Height	Body Surface Area

Drug Allergy/Significant Adverse Reactions		
No known allergies ☐	Reaction	
Medicine / Other	Sign:	Date:
Signature:	Print Name:	Date:

Drugs Not Administered

* ON THE ADMINISTRATION RECORD write the code in the signature box at the time when the drug should have been given.
* IN THE SECTION BELOW write the code, reason and action taken. Entries must be signed by the Registered Practitioner who did not administer the drug.

1 Prescription unclear	**5**	**Patient could not receive**	**9**	**NBM/ unable to swallow**	
2 Allergy	**6**	**Patient refused drug**	**0**	**Other**	
3 Outside range	**7**	**Drug not available**			
4 Patient away from ward	**8**	**On instruction from Dr**			

Date	Time	Reason (See code Above)	Drug	Action Taken	Signature

Medicine Reconciliation

Sources Used (Choose at Least Two Sources if Level 2)

❒ Pts own drugs	❒ GP Surgery	❒ GP repeat prescription	❒ Medication list (self made)	❒ Recent discharge letter
❒ Patient/Carer	❒ GP	❒ Local Chemist	❒ Hospital pharmacy records	❒ Other . . . . .
❒ Relative	❒ Carer	❒ Nursing home letter/tel/fax	❒ Hospital transfer drug chart	❒ Other . . . . .

Please do not send pts own drugs home with relatives after clerking - they need to be reviewed by pharmacy

Communication Difficulties:	**Checklist (tick when complete - list all information below)**									
	Pts own drug	Over the counter	Inhalers / Nebulisers / O_2	Herbal	Topical	Spray	Drop	Inj	Liquid	Rec. Drugs

Dosette Box: Yes ❒ **No** ❒ Chemist: . . . . . .Tel: . . . . . Fax: . . . . . **Alcohol Quantity:** (per week) **Allergies complete** **Smoking:** Quantity / day Cigs ❒ Roll ups ❒

Blister ❒ Multicomponent ❒ other ❒ weekly ❒ fortnightly ❒ monthly ❒ other ❒ or patient to collect ❒

Discrepancies between inpatient medicine administration record and drug history:

Medicine (include formulation and strength)	Regimen	Route	Resolved with Dr/Pharm	Plan Alterations / Additional information

Level 2 Reconciliation by: (PRINT NAME)	**Bleep**	**Pharmacist/other**	**Date**	**Time**	**Signature**
Started:					
Confirmed by::					