The Leeds Teaching Hospitals NHS
NHS Trust

Prescription Chart and Administration Record

Number of these Prescription and Administration Record Charts in use:	1	2	3	Other types of charts in concurrent use:	
Guidelines for prescribers	***Abbreviations***			***Date***	***Chart*** *(delete when finished)*
Approved drug name in full in CAPITALS	IV – Intravenous	PO – Per os (by mouth)	NG – Nasogastric		
Avoid decimal points if possible	IM – Intramuscular	SC – Subcutaneous	PR – Rectal		
Always PRINT your NAME & contact number	Neb – by nebuliser	Top – Topical	INH - Inhalation		

Symptomatic Relief Policy *(for adult patients only)*	***If this is signed, the following drugs can be administered at the nurse's discretion. Maximum of two doses in 24 hours. The nurse will make a record in the ONCE only section for each administration. Prescriber to delete drugs NOT to be administered.***				
Paracetamol tablets / liquid 1g *Senna 2 Tablets / 10mL liquid* *Strepsils lozenges* *Simple linctus 10mL* *Peppermint Water 10mL*	*Alginate Antacid Liquid 10mL* *Glycerine suppository 4g* *Sodium citrate enema* *Diprobase cream* *White Soft Paraffin*	***Sign***	***PRINT name & contact no.***	***Date***	***Pharm***

Once only medicines

Drug (& any additional instructions)	***Dose***	***Route***	***Sign (PRINT NAME & Bleep)***	***Date & Time due***	***Time given***	***Sign***	***Pharm***

Pharmaceutical Care Pathway		***Sign (Name)***	***Date***
	Drug history checked		
	Discharge prescription check		

Pharmacist Medication Review															
	Level:														
	Date:														
	Sign:														

Regular Medicines | Month & year: | Date

ANTI- EMBOLISM STOCKINGS

Instructions | Date

Leg(s): **L** **R** **Both**

PRINT Name & Contact | Sign

DOCTORS: If stockings are not appropriate cross this prescription through clearly.

NURSES: Assess the fit, compliance and skin integrity daily and sign.
Re-measure and change stockings according to clinical need.

18

Drug (VTE Prophylaxis only) | Dose

6

Thromboprophylaxis risk assessment completed | Tick

PRINT Name & Contact | Route | Date

State reason here for NOT prescribing VTE prophylaxis:

Sign | Pharm | Supply

Sign: Date:

Prescribing Instructions
VTE prophylaxis must be considered for all patients. If prophylaxis is appropriate, prescribe according to local guidelines and sign the appropriate prescriptions.

18

Drug (1) | Dose

6

Additional Instructions | Route

8

12

PRINT Name & Contact | Date

14

18

Sign | Pharm | Supply

22

Drug (2) | Dose

6

Additional Instructions | Route

8

12

PRINT Name & Contact | Date

14

18

Sign | Pharm | Supply

22

Drug (3) | Dose

6

Additional Instructions | Route

8

12

PRINT Name & Contact | Date

14

18

Sign | Pharm | Supply

22

Allergies and Adverse Drug Reactions – List the medicines or substances & the nature of the reaction (write NKDA if none)		
It is mandatory to complete this section		
Medicine / Substance	**Reaction**	
Sign	**PRINT Name**	**Date**
Allergy status unconfirmed. Authority to administer medicines ceases after 24 hours.	**Sign (PRINT NAME)**	**Time & Date**

Self Administration Level	**Level**	**Date**	**Sign (and print NAME)**

First name	Surname		
Hospital No:		DOB:	
NHS No:			
Date	Consultant	Ward	Hospital
Date	Consultant	Ward	Hospital
Age (if<18)	Weight	Height	Surface area

PRESCRIBERS - For all antimicrobials write the indication, duration or review date in the 'Additional Instructions' box.

PRESCRIBERS - PRINT your name legibly and sign all prescriptions.

Regular Medicines

			Month & Year:	Date:															
Drug (4)			Dose																
				6															
Additional Instructions			Route	**8**															
				12															
PRINT Name & Contact			Date	**14**															
				18															
Sign	Pharm	Supply		**22**															
Drug (5)			Dose																
				6															
Additional Instructions			Route	**8**															
				12															
PRINT Name & Contact			Date	**14**															
				18															
Sign	Pharm	Supply		**22**															
Drug (6)			Dose																
				6															
Additional Instructions			Route	**8**															
				12															
PRINT Name & Contact			Date	**14**															
				18															
Sign	Pharm	Supply		**22**															
Drug (7)			Dose																
				6															
Additional Instructions			Route	**8**															
				12															
PRINT Name & Contact			Date	**14**															
				18															
Sign	Pharm	Supply		**22**															

Regular Medicines

Month & Year:		Date:														
Drug (8)	Dose															
		6														
Additional Instructions	Route	8														
		12														
PRINT Name & Contact	Date	14														
		18														
Sign	Pharm / Supply	22														
Drug (9)	Dose															
		6														
Additional Instructions	Route	8														
		12														
PRINT Name & Contact	Date	14														
		18														
Sign	Pharm / Supply	22														
Drug (10)	Dose															
		6														
Additional Instructions	Route	8														
		12														
PRINT Name & Contact	Date	14														
		18														
Sign	Pharm / Supply	22														
Drug (11)	Dose															
		6														
Additional Instructions	Route	8														
		12														
PRINT Name & Contact	Date	14														
		18														
Sign	Pharm / Supply	22														

Annotation of prescription date

Use OA if the drug is to be continued, on admission, at the same dose as prior to admission.

Omission codes to be recorded in red ink (see back page for action taken)			
1. Patient away from ward	3. Patient refused	5. Omitted at nurse's discretion	7. Self administered
2. Patient could not take dose	4. Dose not available	6. Dr requested omission	8. Administered late

When required medicines

Drug	Dose	Route	Date													
			Time													
Frequency / Max dose in 24 hours	Instructions	Date	Dose													
			Route													
Sign (PRINT Name & Bleep)	Pharm	Supply	Sign													
			Sign													
Drug	Dose	Route	Date													
			Time													
Frequency / Max dose in 24 hours	Instructions	Date	Dose													
			Route													
Sign (PRINT Name & Bleep)	Pharm	Supply	Sign													
			Sign													
Drug	Dose	Route	Date													
			Time													
Frequency / Max dose in 24 hours	Instructions	Date	Dose													
			Route													
Sign (PRINT Name & Bleep)	Pharm	Supply	Sign													
			Sign													
Drug	Dose	Route	Date													
			Time													
Frequency / Max dose in 24 hours	Instructions	Date	Dose													
			Route													
Sign (PRINT Name & Bleep)	Pharm	Supply	Sign													
			Sign													
Drug	Dose	Route	Date													
			Time													
Frequency / Max dose in 24 hours	Instructions	Date	Dose													
			Route													
Sign (PRINT Name & Bleep)	Pharm	Supply	Sign													
			Sign													
Drug	Dose	Route	Date													
			Time													
Frequency / Max dose in 24 hours	Instructions	Date	Dose													
			Route													
Sign (PRINT Name & Bleep)	Pharm	Supply	Sign													
			Sign													
Drug	Dose	Route	Date													
			Time													
Frequency / Max dose in 24 hours	Instructions	Date	Dose													
			Route													
Sign (PRINT Name & Bleep)	Pharm	Supply	Sign													
			Sign													

Omitted or Delayed Doses

(Code number recorded in RED on main section)

First name:	Surname:
Hospital No:	DOB:

1. Patient away from ward	3. Patient refused	5. Omitted at nurse's discretion	7. Self administered
2. Patient could not take dose	4. Dose not available	6. Dr requested omission	8. Administered late

- Codes 1 - 6 require an action to be taken to prevent further missed doses.

Date & Time	Medicine	Code No	Further details	Action taken	Sign