Patient Name .... Hosp No .... NHS No ....

Prescription Chart (Adult)

NHS Trust

Ward 1	Chart(s) Attached	Tick box
	Insulin	
Ward 2	Subcut Driver	
	Enteral Feed	
Ward 3	MRSA	
	Other:	

Date

Chart re-written: ....

Anticipated discharge: ....

TTO written: ....

Chart .... of ....

Private Patient (tick)

Further information on all medication issues available from Medicines Information on ☏ 6142

Must be completed within 24 hours of admission

Allergies/Sensitivities	Type of Reaction	Sign	Date

Consultant:

Weight: kg

Pregnancy: wks

Surname:

First Name(s):

Hospital No:

NHS No:

Address

DOB: **Sex: M / F**

Medicine Reconciliation (MR)

Consent to access SCR obtained verbally	**Name:**	**Date:**
SCR accessed in patient's best interest	**Name:**	**Date:**

Reference Sources: **1.** Patient **2.** Patients Own Medicines **3.** Repeat prescription **4.** Referral letter **5.** Medicine list from GP **6.** Dossette box **7.** Community MAR chart **8.** Relative / carer **9.** Recent TTA sheet

MR Level	Ref Sources Used (No's see above)	Signature	Date	Time	Referral for Second	Referral for Third	Reason
First							
Second							
Third					Notes:		

Medicines Reconciliation Issues: U = Unintentional I = Intentional

Name/Dose/Freq	Action	Med Rec Resolution	U I	Initial	Date
			U I		
			U I		
			U I		
			U I		
			U I		
			U I		
			U I		
			U I		
			U I		
			U I		
			U I		
			U I		
			U I		

Meds Counselling:	**Chronic Meds**		**New Meds**			

Recent Acute Prescriptions:

Over The Counter Medicines:

Name	Dose/Freq	Date Started	Indication	Comments	Sig	Date

Compliance Aids / Home Support:

Dossette Box supplied by Tel. No: Disp .... weekly TTO supply Y / N

Other compliance aids

Carer support for med admin

Patient Name .... Hosp No .... NHS No ....

Risk Assessment for Venous Thromboembolism (VTE)

All patients should be risk assessed on admission to hospital. Patients should be reassessed within 24 hours of admission and whenever the clinical situation changes.

STEP ONE
Assess all patients admitted to hospital for level of mobility (tick one box). All surgical patients and all medical patients with significantly reduced mobility should be considered for further risk assessment.

STEP TWO
Review the patient related factors shown on the assessment sheet against **thrombosis** risk, ticking each box that applies (more than one box can be ticked).
Any tick for thrombosis risk should prompt Thromboprophylaxis according to NICE guidelines.
The risk factors identified are not exhaustive. Clinicians may consider additional risks in individual patients and offer Thromboprophylaxis as appropriate.

STEP THREE
Review the patient related factors shown against **bleeding risk** and tick each box that applies (more than one box can be ticked).
Any tick should prompt clinical staff to consider if bleeding risk is sufficient to preclude pharmacological intervention.

STEP FOUR
Any patient requiring Thromboprophylaxis must have this documented on the drug chart and the appropriate approved LMWH prescribed in-line with the Trust guidelines. Patients requiring Thromboprophylaxis in whom bleeding risks have been identified should have a risk/benefit analysis performed the outcome documented on the drug chart and the relevant drugs prescribed where appropriate.

STEP FIVE
All patients must be reassessed 24 hours after admission and the assessment form signed in the relevant section at the bottom of the form.
Medical patients must be reassessed at least every 7 days or when their clinical condition changes.
Surgical patients must be reassessed 24 hours post op and whenever their clinical condition changes

Extended prophylaxis should be considered for patients undergoing hip and knee joint surgery, major cancer surgery and for patients who will have significant reduced mobility post discharge

Contra-indications for LMWH) ***(consider mechanical prophylaxis)***	***Contraindications for Mechanical Prophylaxis*** ***(Consider LMWH)***
• **Cr Cl <20ml/min – consider reduced dose see local guidelines** • Active bleeding • Thrombocytopenia (platelets <75 x 10^9/l) • Known bleeding disorder • Previous heparin sensitivity or HIT • On therapeutic anticoagulation	• Severe peripheral vascular disease • Severe dermatitis • Leg oedema • Leg deformity • Peripheral neuropathy • Recent skin graft

Alternations to written prescriptions are **not** allowed. To change dose, route or frequency you must re-write the prescription

Patient Name .... Hosp No .... NHS No ....

Risk assessment For Venous Thromboembolism (VTE)

Assessors Name: _______________ **Assessors Signature:** _______________ **Assessment Date:**________

STEP ONE - Mobility all pts (*Tick one box*)	**Tick**		**Tick**		**Tick**
Surgical patient		Medical patient expected to have ongoing reduced mobility relative to normal state		Medical patient NOT expected to have significantly reduced mobility relative to normal state	

Assess for thrombosis and bleeding risk below

STEP TWO - Thrombosis risk	**Tick**			**Tick**	
Patient related	1st	2nd	**Admission related**	1st	2nd
Active cancer or cancer treatment			Significantly reduced mobility for 3 days or more		
Age > 60			Hip or knee replacement		
Dehydration			Hip fracture		
Known thrombophilias			Total anaesthetic + surgical time > 90 minutes		
Obesity (BMI >30 kg/m^2)			Surgery involving pelvis or lower limb with a total anaesthetic + surgical time > 60 minutes		
One or more significant medical co morbidities (e.g. heart disease; metabolic, endocrine or respiratory pathologies; acute infectious diseases; inflammatory conditions)			Acute surgical admission with inflammatory or intra-abdominal condition		
Personal history or first-degree relative with a history of VTE			Critical care admission		
Use of hormone replacement therapy			Surgery with significant reduction in mobility		
Use of oestrogen-containing contraceptive therapy					
Varicose veins with phlebitis					
Pregnancy or < 6 weeks post partum (see NICE guidance for specific risk factors)					

STEP THREE - Bleeding risk	**Tick**			**Tick**	
Patient related	1st	2nd	**Admission related**	1st	2nd
Active bleeding			Neurosurgery, spinal surgery or orbital surgery		
Acquired bleeding disorders (such as acute liver failure)			Other procedure with high bleeding risk		
Concurrent use of anticoagulants known to increase the risk of bleeding (such as warfarin with INR >2 or treatment dose of LMWH)			Lumbar puncture / epidural / spinal anaesthesia expected within the next 12 hours		
Acute stroke			Lumbar puncture / epidural / spinal anaesthesia within the previous 4 hours		
Thrombocytopaenia (platelets< $75x10^9$/l)					
Uncontrolled systolic hypertension (230/120 mmHg or higher)					
Untreated inherited bleeding disorders (such as haemophilia and von Willebrand's disease)					

STEP FOUR – Sign the assessment & Prescribe

Pharmaceutical prophylaxis Yes / No	**Mechanical prophylaxis (e.g. TED stockings) Yes / No**

STEP FIVE – Re-assess, make changes to prophylaxis as indicated by re-assessment and sign below

24 hours post admission re-assessment	**Signature:**	**Bleep:**	**Date:**
Re-assessment	**Signature:**	**Bleep:**	**Date:**
Re-assessment	**Signature:**	**Bleep:**	**Date:**

Alternations to written prescriptions are **not** allowed. To change dose, route or frequency you must re-write the prescription

Patient Name .... Hosp No .... NHS No ....

Self-Management of Diabetes whilst in Hospital Assessment and Consent Form

Assessment Criteria for Patient

1. Is the ward environment safe for self-administration?	5. Has the patient read and understood the self-management of diabetes whilst in hospital patient information leaflet?
2. Is the patient of sound mind, has mental capacity and is willing to self-manage their diabetes?	6. Patient is not receiving treatment that might impact on diabetes control outside the experience of the individual (e.g. steroid treatment)?
3. Does the patient have the knowledge and skills about their insulin / exenatide / liraglutide and diabetes to self-medicate? (i.e. able to measure own blood glucose levels, understands the effect of food, exercise and illness on blood glucose levels, knows acceptable target blood glucose range, able to recognise and respond to warning signs of hypos, able to inject own insulin, exenatide or liraglutide)	7. Does the patient have no other risk factors that currently make them unsuitable to self-manage their diabetes? (i.e. no unresolved risk of drug abuse / overdose, alcoholism, self-harming, non-adherence or suspected non-adherence, sliding scale, poor glycaemic control, anaesthetised within the past 24 hours, PCA pump in progress)
4. Is the patient responsible for administering their own insulin / exenatide or liraglutide independently in the community?	8. Can the patient physically self-administer own insulin, exenatide or liraglutide?

Criteria	Date of Patient Assessment																				
1																					
2																					
3																					
4																					
5																					
6																					
7																					
8																					
Suitable?																					
Sign																					

Any 'No' answers to questions 1 to 8 - **unsuitable** for self-management	Yes to questions 1 to 8 - **suitable** for self-management

PATIENT CONSENT

I wish to take responsibility for managing my diabetes (blood glucose monitoring and insulin adjustment) during my admission to Hinchingbrooke Healthcare NHS Trust. I agree that:

- I will keep my insulin, exenatide, liraglutide, sharps box, needles and syringes safe and inaccessible to other patients
- I will check my blood glucose regularly with my own meter and record the results
- I will have one blood glucose level checked each morning on a hospital blood glucose monitoring meter
- I will record the dose of insulin taken and make the information available to staff
- If I am unable, for any reason, to make decisions about my diabetes management, medical or nursing staff should make decisions on my behalf until I am able to resume self-management

Signed:.. **PRINT name:**... **Date:**..........................

Patient has been assessed, consented and has no exclusion criteria (as listed in the procedure for self-management of diabetes whilst in hospital). Patient has ☐ a blood glucose meter and monitoring diary, ☐ a sharps box and ☐ a tube of glucogel, ☐ needles **(tick when complete)**.

Signed:.. **PRINT name:**..

Position:.. **Date:**..

WITHDRAWAL OF CONSENT

With immediate effect I wish to withdraw from the self-management of diabetes scheme.

Patient Signature ....

Date: .... **Time:** ....

Healthcare Professionals Signature .... **Date:** .... **Time:** ....

Patient Name .... Hosp No .... NHS No ....

Prescribing and Administration Instructions

Prescriber instructions:

1. Sign for all medicines to legalise prescription with full signature and bleep number
2. Use approved names and block letters
3. Sign and date allergies box. If there are no allergies then write "none known"
4. Circle preset rounds or write specific admin times
5. Discontinue drug with a double line vertically through row, then date and sign
6. Different doses of the same medicine must be prescribed on separate lines
7. Write micrograms and units in full

Administration instructions:

1. Nurse to initial each dose in the appropriate box at the time of administration (administration must be witnessed)
2. Each column in the "regular Rx section" corresponds to one day, do **not** use the same column for different dates
3. Two signatures are required for IV treatment, controlled drugs and chemotherapy

Missed Dose Codes

If a dose is not given, or patient self-medicating, please enter code as below:

1. Patient not on ward
2. Drug omitted for clinical reason
3. Drug not currently available
4. Patient refused to take drug
5. Patient self-medicating
6. Incomplete or impossible script
7. Nil by mouth
8. Other documented reason

Other Reason	Date	Time

Once Only & Stat Dose

Pharm	Date req'd	Time req'd	Medicine	Dose	Route	Dr's Sig & bleep No.	Given by	Time given

Alternations to written prescriptions are **not** allowed. To change dose, route or frequency you must re-write the prescription

Patient Name .... Hosp No .... NHS No ....

SURGICAL ANALGESIC PATHWAYS ONLY

Prescribing and Administration Instructions

Prescriber instructions:

- This section is to be used **only** for medicines that are part of the analgesic surgical pathways. Other drugs are to be written on the main prescription chart.
- Sign with full signature and add bleep number, complete start date, complete dose and course length (where appropriate) for items required according to the appropriate Guidelines.
- Cross off any pre-printed drugs with a double line vertically through row which are not required.
- Cross off any pre-printed drugs with a double line vertically through row which the patient has an allergy to.

Administration instructions:

- Only administer medications that are signed and dated.
- Nurse to initial each dose in the appropriate box at the time of administration (administration must be witnessed).
- Each column in the “regular Rx section” corresponds to one day; do **not** use the same column for different dates.
- Two signatures are required for IV treatment and controlled drugs.

ONCE ONLY & STAT DOSE PATHWAY MEDICATION

Sign and Date according to Guidelines

Pharm	Analgesic Pathway	Date req'd	Time req'd	Medicine	Dose	Route	Dr's Sig & bleep No.	Given by	Time given
	Hip/ Knee Shoulder #NOF		2 hours pre-op	Ondansetron	4mg	PO			
	Spinal Gynae Colorectal		2 hours pre-op	Metoclopramide *(not with Parkinsons, age <20, supplied under PGD at pre-op)*	10mg	PO			
	Hip/ Knee Shoulder Spinal Gynae Colorectal		2 hours pre-op	Gabapentin	300mg	PO			
	Hip/ Knee Shoulder		At Induction	Tranexamic acid	15mg/ kg	IV			
	See Trust ‘Surgical Antibiotic Prophylaxis Guidelines’		At Induction	Gentamicin	160mg	IV			
				Teicoplanin	400mg	IV			
				Co-Amoxiclav	1.2g	IV			
				Metronidazole	500mg	IV			
	Hip/ Knee Shoulder Gynae Colorectal		6 hours post-op *(if on free fluids)*	Gabapentin	300mg	PO			
	Hip/ Knee Shoulder Spinal #NOF Gynae		6 hours post-op	LMWH ……………………	……….. units	SC			

COLORECTAL SURGERY ONLY Sign and Date according to Guidelines

Pharm	Date req'd	Time req'd	Medicine	Dose	Route	Dr's Sig & bleep No.	Given by	Time given
From Pre-Op Clinic		P.M. day before, and A.M. of surgery day	Pre-op Carbohydrate Drink	6 x 200ml	PO		N/A	N/A
From Pre-Op Clinic		P.M. day before surgery	Phosphate Enema	1 bottle	PR		N/A	N/A
		On admission	Phosphate Enema	1 bottle	PR			

Alternations to written prescriptions are **not** allowed. To change dose, route or frequency you must re-write the prescription

Patient Name .... Hosp No .... NHS No ....

SURGICAL ANALGESIC PATHWAYS ONLY

REGULAR PATHWAY MEDICATION

Sign and Date according to Guidelines

Medicine	Pharmacy / Info		Time	Date	Date	Date	Date	Date	Date	Date
Medicine: **Paracetamol** — ***MAXIMUM 3g I/V and 4g PO IN 24 HOURS***	Pharmacy	✓	Breakfast							
Dose*: / Frequency: TDS/QDS / Route: PO/I/V	*Dose Info **1g** **I/V only: If < 50 kg dose is 15mg /kg**	✓	Midday							
		✓	Evening							
Dr's Sig & Bleep No. / Start Date	Stop Date	✓	Night							
Medicine: **Oxycodone MR Tablets** — ***SEE NOTE BELOW FOR DOSE****	Pharmacy: CD	✓	06:00							
	Additional info		Breakfast							
Dose: / Frequency: BD / Route: PO			Midday							
		✓	18:00							
			Evening							
Dr's Sig & Bleep No. / Start Date	Stop Date: After 3 days		Night							
Medicine: **Buprenorphine Patch** — **# NOF SURGERY ONLY** — ***NOT WITH OXYCODONE MR***	Pharmacy: CD	✓	Breakfast							
Dose: 5 microgram / Frequency: 7days / Route: TOP	Additional info: **FOR PATIENTS NON-COMPLIANT WITH ORAL MEDICATION**		Midday							
			Evening							
Dr's Sig & Bleep No. / Start Date	Stop Date: After 7 days		Night							
Medicine: **Targinact® 10/5mg Tablet** — **COLORECTAL SURGERY ONLY**	Pharmacy: CD	✓	06:00							
	Additional info		Breakfast							
Dose: 1-2 Tab / Frequency: BD / Route: PO			Midday							
		✓	18:00							
			Evening							
Dr's Sig & Bleep No. / Start Date	Stop Date: After 3 Days		Night							
Medicine: **Gabapentin Capsules** — **SPINAL SURGERY ONLY**	Pharmacy	✓	Breakfast							
	Additional info: **AVOID IF RENAL IMPAIRMENT**		Midday							
Dose: 300mg / Frequency: BD / Route: PO			Evening							
Dr's Sig & Bleep No. / Start Date	Stop Date: After 3 Days	✓	Night							

***DOSE OF OXYCODONE MR:**

- **HIP, KNEE, SHOULDER SURGERY: 10mg (age ≤ 75) or 5mg (age ≥ 76)**
- **SPINAL, FRACTURED NECK OF FEMUR SURGERY: 5 mg**

Alternations to written prescriptions are **not** allowed. To change dose, route or frequency you must re-write the prescription

Patient Name .... Hosp No .... NHS No ....

SURGICAL ANALGESIC PATHWAYS ONLY

REGULAR PATHWAY MEDICATION

Sign and Date according to Guidelines

Medicine			Pharmacy		Time	Date	Date	Date	Date	Date	Date	Date
Ibuprofen **SEE PRESCRIBING GUIDANCE BELOW**				✓	Breakfast							
			Additional info	✓	Midday							
Dose 400mg	Frequency TDS	Route PO		✓	Evening							
Dr's Sig & Bleep No.		Start Date	Stop Date		Night							
Medicine Omeprazole **IF IBUPROFEN STARTED, >65YRS, NOT ON PPI**			Pharmacy		06:00							
				✓	Breakfast							
			Additional info		Midday							
Dose 20mg	Frequency OD	Route PO			18:00							
					Evening							
Dr's Sig & Bleep No.		Start Date	Stop Date		Night							
Medicine Lactulose Solution			Pharmacy	✓	Breakfast							
			Additional info **CONSIDER IN COLORECTAL SURGERY AFTER 3 DAYS**		Midday							
Dose 10 to15ml	Frequency BD	Route PO		✓	Evening							
Dr's Sig & Bleep No.		Start Date	Stop Date		Night							
Medicine Senna 7.5mgTablet			Pharmacy		Breakfast							
			Additional info **AVOID IN COLORECTAL SURGERY**		Midday							
Dose 2 Tab	Frequency ON	Route PO			Evening							
Dr's Sig & Bleep No.		Start Date	Stop Date	✓	Night							
Medicine			Pharmacy		Breakfast							
			Additional info		Midday							
Dose	Frequency	Route			Evening							
Dr's Sig & Bleep No.		Start Date	Stop Date		Night							

IBUPROFEN IS CONTRAINDICATED:

- **In Hip, Knee, Shoulder surgery if ≥ 76 years**
- **In Spinal and Colorectal Surgery for first 24 hours**
- **In NOF Surgery unless exceptions (see Guidelines)**
- **In NSAID induced asthma, Renal impairment, Heart failure, GI Intolerance**

Alternations to written prescriptions are **not** allowed. To change dose, route or frequency you must re-write the prescription

Patient Name .... Hosp No .... NHS No ....

SURGICAL ANALGESIC PATHWAYS ONLY

WHEN REQUIRED PATHWAY MEDICATION

Sign and Date according to Guidelines

Medicine Tramadol 50mg **NOT WITH CODEINE** ***SEE NOTE BELOW FOR DOSE****		Pharmacy CD	Date													
		Indication **1ST LINE, AVOID WITH SSRI/ EPILEPSY**	Dose													
Dose	Minimum interval	Route PO	Time													
Dr's Sig & Bleep No.		Date	Sign													

Medicine Codeine 30mg **NOT WITH TRAMADOL** ***SEE NOTE BELOW FOR DOSE****		Pharmacy	Date													
		Indication **AVOID IN COLO-RECTAL SURGERY**	Dose													
Dose	Minimum interval	Route	Time													
Dr's Sig & Bleep No.		Date	Sign													

Medicine Oxycodone Liquid 5mg in 5ml **ORTHOPAEDIC USE ONLY**		Pharmacy CD	Date													
		Indication **2nd LINE**	Dose													
Dose 5 to 10mg	Minimum interval 2 hours	Route PO	Time													
Dr's Sig & Bleep No.		Date	Sign													

Medicine Ondansetron		Pharmacy	Date													
		Indication	Dose													
Dose 4mg	Minimum interval 8 hours	Route PO/IV	Time													
Dr's Sig & Bleep No.		Date	Sign													

Medicine		Pharmacy	Date													
		Indication	Dose													
Dose	Minimum interval	Route	Time													
Dr's Sig & Bleep No.		Date	Sign													

***DOSE OF TRAMADOL AND CODEINE:**

- **One to Two QDS: Cr Cl > 20 ml/min**
- **One to Two TDS: Cr Cl 10-20 ml/min**
- **One TDS: Cr Cl <10ml/min**

NOTE CODEINE IS CONTRAINDICATED IN COLORECTAL SURGERY

Alternations to written prescriptions are **not** allowed. To change dose, route or frequency you must re-write the prescription

Patient Name .... Hosp No .... NHS No ....

Inpatient Acute Pain Management Prescription (Adult)

Spinal/Epidural Diamorphine Administered Date .... Time....................... (Full nursing assessment must be completed BEFORE COMMENCEMENT OF PCA or administration of strong opioids via any other route)	Epidural in Progress Please refer to Epidural Prescription chart Date - Signed -

PCA: MORPHINE SULPHATE 50mg/50mLs Sodium Chloride 0.9%	DOSE	Dr's sig ....
OR	.... mg/hr background	Bleep no: .... Date ....
Drug:	.... to ....mg bolus	Loading Bolus Dose — Only by recovery or Acute Pain Team — Range 0 to 5 mg ....mg
Diluent:	...................minute lock-out	Date:
ROUTE INTRAVENOUS	Repeat ....times	Time:
		Sig's:

Start Date								
Start Time								
Nurse Sig's								
Unused Vol	mLs	mLs	mLs	mLs	mLs	mLs	mLs	mLs

IV Bolus Analgesia – (Adults only)

		Administration Record												
MORPHINE 1mg/mL Bolus Dose ....mg at 5min intervals		Date												
FOR USE BY RECOVERY STAFF & ACUTE PAIN TEAM ONLY		Time												
Can be repeated by Acute pain team		Dose												
Date:	Max total dose:	Sig's												
Dr's Signature:	Bleep No.	Total given												

Oral Bolus Analgesia

Morphine Sulphate 10mg/5mLs soln

Age (yrs)	Dose (circle as appropriate)	
16 to 39	15 to 25mg	**Not with PCA or Epidural Minimum dose interval 90mins**
40 to 59	10 to 20mg	
60 to 69	10 to 15mg	
>70	5 to 10mg	
Dr's sig & bleep No.	Date	

Administration Record

Date													
Time													
Dose													
Sig													
Date													
Time													
Dose													
Sig													

Rescue Medicine

OPOIDINDUCED RESPIRATORY DEPRESSION

Naloxone **100 to 200micrograms iv stat followed by 100micrograms every 2 mins PRN**

Dr's sig & bleep No. Date

Administration Record

Date						
Time						
Dose						
Route						
Sign						

Alternations to written prescriptions are **not** allowed. To change dose, route or frequency you must re-write the prescription

Patient Name .... Hosp No .... NHS No ....

IM Bolus Analgesia

Route only to be used as last resort. Inform the Acute Pain Team

Morphine Sulphate 10mg/mL inj

Age (yrs)	Dose (circle as appropriate)	
16 to 39	10 to 15mg	**Not with PCA or Epidural**
40 to 59	5 to 10mg	**Minimum dose interval 60mins**
60 to 69	5 to 7.5mg	
>70	2.5 to 5mg	

Date							
Time							
Dose							
Sig's							

Dr's sig & bleep No.

Antiemetics

Dr to delete inappropriate routes

Drug	Administration Record											
	Date											
Ondansetron 4mg TDS po / iv / im	Time											
Dr's sig & bleep No. Date	Route											
	Sig											
Cyclizine 50mg TDS po / im / slow iv	Time											
Dr's sig & bleep No Date	Route											
	Sig											
Prochlorperazine 10mg po TDS/12.5mg im	Time											
Dr's sig & bleep No. Date	Route											
	Sig											
Metoclopramide 10mg TDS po / im / iv	Time											
Dr's sig & bleep No. Date	Route											
	Sig											

Discharge Prescription

Doctor to sign & date against each item & prescribe any additional medicines

Name, Quantity	Dose, frequency	Dr's Sig & bleep	Date	Supplied	Date
Paracetamol 500mg Tablets 32 tablets	ONE or TWO tablets every 4 to 6 hours				
Codeine 30mg Tablets 28 tablets	ONE or TWO tablets every 4 to 6 hours when required				
Morphine Sulphate Solution 10mg/5ml 100ml	2.5 to 5ml FOUR times a day when necessary for pain				
Ibuprofen 400mg Tablets 24 tablets	ONE tablet THREE times daily				
Lactulose	10-15ml twice a day				
LMWH .... **Dose** .... **Course Length**	daily SC				
Patient's Own Drugs (PODs)	Dr to sign if all PODs to be returned to patient.				

Additional Discharge Medicines

Name, Form	Dose, Freq	Route	Duration	Dr's Sig & bleep	Date	Supplied	Date

Alternations to written prescriptions are **not** allowed. To change dose, route or frequency you must re-write the prescription

Patient Name .... Hosp No .... NHS No ....

NB: Co-Amoxiclav, Augmentin®, Tazocin®, Piperacillin and Flucloxacillin are Penicillins

Anti Infectives ONLY (surgical prophylaxis antibiotics to be prescribed on Once Only section page 5/6)

Prescribing Notes: All antibiotic prescriptions must have an indication and stop / review date stated at time of prescribing.

Medicine				Time	Date							
Dose	Frequency	Route	Start		Breakfast							
Prescriber's full signature & bleep No.			Stop (end of)		Midday							
Allergies checked	Initials:		Review Date		Evening							
Indication			Pharmacy		Night							
Medicine				Time	Date							
Dose	Frequency	Route	Start		Breakfast							
Prescriber's full signature & bleep No.			Stop (end of)		Midday							
Allergies checked	Initials:		Review Date		Evening							
Indication			Pharmacy		Night							
Medicine				Time	Date							
Dose	Frequency	Route	Start		Breakfast							
Prescriber's full signature & bleep No.			Stop (end of)		Midday							
Allergies checked	Initials:		Review Date		Evening							
Indication			Pharmacy		Night							
Medicine				Time	Date							
Dose	Frequency	Route	Start		Breakfast							
Prescriber's full signature & bleep No.			Stop (end of)		Midday							
Allergies checked	Initials:		Review Date		Evening							
Indication			Pharmacy		Night							
Medicine				Time	Date							
Dose	Frequency	Route	Start		Breakfast							
Prescriber's full signature & bleep No.			Stop (end of)		Midday							
Allergies checked	Initials:		Review Date		Evening							
Indication			Pharmacy		Night							

IV antibiotics are rarely needed for longer than 72 hours (except for meningitis, endocarditis, immunosuppression, bone/joint infection, deep abscess, cystic fibrosis). Please review suitability for any IV antibiotic to be switched to oral treatment.

Alternations to written prescriptions are **not** allowed. To change dose, route or frequency you must re-write the prescription

Patient Name .... Hosp No .... NHS No ....

Anti Infectives ONLY (surgical prophylaxis antibiotics to be prescribed on Once Only section page 5/6)

PPI's and Antibiotics linked to *C.difficile* infection – review indication regularly, stop inappropriate prescriptions.

Medicine				Time	Date								
Dose	Frequency	Route	Start		Breakfast								
Prescriber's full signature & bleep No.			Stop (end of)		Midday								
Allergies checked	Initials:		Review Date		Evening								
Indication			Pharmacy		Night								

Medicine				Time	Date								
Dose	Frequency	Route	Start		Breakfast								
Prescriber's full signature & bleep No.			Stop (end of)		Midday								
Allergies checked	Initials:		Review Date		Evening								
Indication			Pharmacy		Night								

Medicine				Time	Date								
Dose	Frequency	Route	Start		Breakfast								
Prescriber's full signature & bleep No.			Stop (end of)		Midday								
Allergies checked	Initials:		Review Date		Evening								
Indication			Pharmacy		Night								

Medicine				Time	Date								
Dose	Frequency	Route	Start		Breakfast								
Prescriber's full signature & bleep No.			Stop (end of)		Midday								
Allergies checked	Initials:		Review Date		Evening								
Indication			Pharmacy		Night								

Medicine				Time	Date								
Dose	Frequency	Route	Start		Breakfast								
Prescriber's full signature & bleep No.			Stop (end of)		Midday								
Allergies checked	Initials:		Review Date		Evening								
Indication			Pharmacy		Night								

IV antibiotics are rarely needed for longer than 72 hours (except for meningitis, endocarditis, immunosuppression, bone/joint infection, deep abscess, cystic fibrosis).
Please review suitability for any IV antibiotic to be switched to oral treatment.

Alternations to written prescriptions are **not** allowed. To change dose, route or frequency you must re-write the prescription

Patient Name .... Hosp No .... NHS No ....

Regular Prescriptions (Prescribe Anti Infectives on page 10 & 11)

1 OXYGEN

Target Saturation (please circle)	Device (see codes)	O_2 flow L/min	PRN / Continuous	Duration	Additional Instructions e.g. nurse to wean or max flow rate	Morning
88 – 92%						
93 – 98%	Change 1					
Not indicated	Change 2					

Device codes: V = Venturi N – Nasal Cannulae H = Humidified Oxygen NIV = Non Invasive Ventilation RM = Reservoir Mask TM = Tracheotomy Mask O = other CP = Patient on CPAP

Prescriber's sig & bleep number Date

Night

Low Molecular Weight Heparin

Pharmacy	2 LMWH		Additional info - **Refer to the patients' VTE Thromboprophylaxis Risk Assessment**			Time
			Prescriber's sig & bleep number			Breakfast
	Dose	Frequency	Route	Start Date	Stop Date	Midday
						Evening
						Night
Pharmacy	**TED Stockings** L R Both		**Prescriber's sig** & bleep number			**In use = sig Not in use = x**

Oral Anticoagulant

Pharmacy	3 Warfarin		Target INR:	Indication:	Course duration:	**Date:**
			Prescriber's full sig & bleep number			**INR Result:**
	Dose	Frequency	Route	Start Date	Stop Date	**Dose: Evening**
	See admin page	**OD (at 18:00)**	**PO**			**Nurse's Sig:**

Regular Medicines

Pharmacy	4 Medicine		Additional info			
						Breakfast
			Prescriber's sig & bleep number			Midday
	Dose	Frequency	Route	Start Date	Stop Date	Evening
						Night
Pharmacy	5 Medicine		Additional info			
						Breakfast
			Prescriber's sig & bleep number			Midday
	Dose	Frequency	Route	Start Date	Stop Date	Evening
						Night

Alternations to written prescriptions are **not** allowed. To change dose, route or frequency you must re-write the prescription

Patient Name .... Hosp No .... NHS No ....

Regular Medicines Administration (missed doses refer to instructions on page 5)

Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date

Oxygen saturations must be recorded on the patient monitoring chart. Nurses must sign the Prescription chart twice daily (morning and night) to confirm oxygen therapy and monitoring is on-going

Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date

Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR
Dose mg	Dose mg	Dose mg	Dose mg	Dose mg	Dose mg	Dose mg	Dose mg	Dose mg	Dose mg	Dose mg	Dose mg	Dose mg	Dose mg	Dose mg	Dose mg	Dose mg	Dose mg	Dose mg	Dose mg	Dose mg
Sig	Sig	Sig	Sig	Sig	Sig	Sig	Sig	Sig	Sig	Sig	Sig	Sig	Sig	Sig	Sig	Sig	Sig	Sig	Sig	Sig

Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date

Alternations to written prescriptions are **not** allowed. To change dose, route or frequency you must re-write the prescription

Patient Name .... Hosp No .... NHS No ....

Regular Prescriptions (Prescribe Anti Infectives on page 10 & 11)

Pharmacy	Medicine		Additional info			Time	
Pharmacy	6 **Medicine**		Additional info				
							Breakfast
			Prescriber's sig & bleep number				
							Midday
	Dose	Frequency	Route	Start Date	Stop Date		
							Evening
							Night
Pharmacy	7 **Medicine**		Additional info				
							Breakfast
			Prescriber's sig & bleep number				
							Midday
	Dose	Frequency	Route	Start Date	Stop Date		
							Evening
							Night
Pharmacy	8 **Medicine**		Additional info				
							Breakfast
			Prescriber's sig & bleep number				
							Midday
	Dose	Frequency	Route	Start Date	Stop Date		
							Evening
							Night
Pharmacy	9 **Medicine**		Additional info				
							Breakfast
			Prescriber's sig & bleep number				
							Midday
	Dose	Frequency	Route	Start Date	Stop Date		
							Evening
							Night
Pharmacy	10 **Medicine**		Additional info				
							Breakfast
			Prescriber's sig & bleep number				
							Midday
	Dose	Frequency	Route	Start Date	Stop Date		
							Evening
							Night
Pharmacy	11 **Medicine**		Additional info				
							Breakfast
			Prescriber's sig & bleep number				
							Midday
	Dose	Frequency	Route	Start Date	Stop Date		
							Evening
							Night
Pharmacy	12 **Medicine**		Additional info				
							Breakfast
			Prescriber's sig & bleep number				
							Midday
	Dose	Frequency	Route	Start Date	Stop Date		
							Evening
							Night

Alternations to written prescriptions are **not** allowed. To change dose, route or frequency you must re-write the prescription

Patient Name .... Hosp No .... NHS No ....

Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date

Alternations to written prescriptions are **not** allowed. To change dose, route or frequency you must re-write the prescription

Patient Name .... Hosp No .... NHS No ....

Regular Prescriptions (Prescribe Anti Infectives on page 10 & 11)

						Time	
Pharmacy	13 **Medicine**		Additional info				Breakfast
			Prescriber's sig & bleep number				Midday
	Dose	Frequency	Route	Start Date	Stop Date		Evening
							Night
Pharmacy	14 **Medicine**		Additional info				Breakfast
			Prescriber's sig & bleep number				Midday
	Dose	Frequency	Route	Start Date	Stop Date		Evening
							Night
Pharmacy	15 **Medicine**		Additional info				Breakfast
			Prescriber's sig & bleep number				Midday
	Dose	Frequency	Route	Start Date	Stop Date		Evening
							Night
Pharmacy	16 **Medicine**		Additional info				Breakfast
			Prescriber's sig & bleep number				Midday
	Dose	Frequency	Route	Start Date	Stop Date		Evening
							Night
Pharmacy	17 **Medicine**		Additional info				Breakfast
			Prescriber's sig & bleep number				Midday
	Dose	Frequency	Route	Start Date	Stop Date		Evening
							Night
Pharmacy	18 **Medicine**		Additional info				Breakfast
			Prescriber's sig & bleep number				Midday
	Dose	Frequency	Route	Start Date	Stop Date		Evening
							Night
Pharmacy	19 **Medicine**		Additional info				Breakfast
			Prescriber's sig & bleep number				Midday
	Dose	Frequency	Route	Start Date	Stop Date		Evening
							Night

Alterations to written prescription are **not** allowed. To change dose, route or frequency you must re-write the prescription.
N/F = Non Formulary, S = Stock, POD = Pts Own Drugs, H =Drug History Correct, CD = Controlled Drug, PODH = Pts Own Drug at Home

Patient Name .... Hosp No .... NHS No ....

Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date

Alternations to written prescriptions are **not** allowed. To change dose, route or frequency you must re-write the prescription

Patient Name .... Hosp No .... NHS No ....

When Required 'PRN' Medication

Medicine		Pharmacy	Date													
		Indication	Dose													
Dose	Minimum interval	Route	Time													
Dr's Sig & Bleep No.		Date	Sign													
Medicine		Pharmacy	Date													
		Indication	Dose													
Dose	Minimum interval	Route	Time													
Dr's Sig & Bleep No.		Date	Sign													
Medicine		Pharmacy	Date													
		Indication	Dose													
Dose	Minimum interval	Route	Time													
Dr's Sig & Bleep No.		Date	Sign													
Medicine		Pharmacy	Date													
		Indication	Dose													
Dose	Minimum interval	Route	Time													
Dr's Sig & Bleep No.		Date	Sign													
Medicine		Pharmacy	Date													
		Indication	Dose													
Dose	Minimum interval	Route	Time													
Dr's Sig & Bleep No.		Date	Sign													
Medicine		Pharmacy	Date													
		Indication	Dose													
Dose	Minimum interval	Route	Time													
Dr's Sig & Bleep No.		Date	Sign													
Medicine		Pharmacy	Date													
		Indication	Dose													
Dose	Minimum interval	Route	Time													
Dr's Sig & Bleep No.		Date	Sign													
Medicine		Pharmacy	Date													
		Indication	Dose													
Dose	Minimum interval	Route	Time													
Dr's Sig & Bleep No.		Date	Sign													

Alterations to written prescription are **not** allowed. To change dose, route or frequency you must re-write the prescription.
N/F = Non Formulary, S = Stock, POD = Pts Own Drugs, H =Drug History Correct, CD = Controlled Drug, PODH = Pts Own Drug at Home

Patient Name .... Hosp No .... NHS No ....

When Required 'PRN' Medication

Medicine		Pharmacy	Date													
		Indication	Dose													
Dose	Minimum interval	Route	Time													
Dr's Sig & Bleep No.		Date	Sign													
Medicine		Pharmacy	Date													
		Indication	Dose													
Dose	Minimum interval	Route	Time													
Dr's Sig & Bleep No.		Date	Sign													
Medicine		Pharmacy	Date													
		Indication	Dose													
Dose	Minimum interval	Route	Time													
Dr's Sig & Bleep No.		Date	Sign													
Medicine		Pharmacy	Date													
		Indication	Dose													
Dose	Minimum interval	Route	Time													
Dr's Sig & Bleep No.		Date	Sign													
Medicine		Pharmacy	Date													
		Indication	Dose													
Dose	Minimum interval	Route	Time													
Dr's Sig & Bleep No.		Date	Sign													
Medicine		Pharmacy	Date													
		Indication	Dose													
Dose	Minimum interval	Route	Time													
Dr's Sig & Bleep No.		Date	Sign													
Medicine		Pharmacy	Date													
		Indication	Dose													
Dose	Minimum interval	Route	Time													
Dr's Sig & Bleep No.		Date	Sign													
Medicine		Pharmacy	Date													
		Indication	Dose													
Dose	Minimum interval	Route	Time													
Dr's Sig & Bleep No.		Date	Sign													

Alternations to written prescriptions are **not** allowed. To change dose, route or frequency you must re-write the prescription

Patient Name .... Hosp No .... NHS No ....

PARENTERAL INFUSION PRESCRIPTION AND RECORD OF ADMINISTRATION

NOT TO BE USED FOR BLOOD PRODUCTS

Parenteral Infusion Prescription								Record of Administration				
Pharm	Date	Line	Type of fluid	Additives / Instructions	Vol	Rate	Drs' signature & bleep No.	Batch No	Date & time started	Nurses' initials	Date & time discont	Amount given
			Sodium Chloride 0.9%	Peripheral flush	5 -10mL			Administer pre and post iv bolus / intermittent infusion				

Alterations to written prescription are **not** allowed. To change dose, route or frequency you must re-write the prescription.

Patient Name .... Hosp No .... NHS No ....

Parenteral Infusion Prescription								Record of Administration					
Pharm	Date	Line	Type of fluid	Additives / Instructions	Vol	Rate	Drs' signature & bleep No.	Batch No	Date & time started	Nurses' initials		Date & time discont	Amount given

Alterations to written prescription are **not** allowed. To change dose, route or frequency you must re-write the prescription.

Patient Name .... Hosp No .... NHS No ....

Patient's Own Drugs (POD) record

This form is not intended to be used as a complete drug history

Name of Medicine	Form	Strength	Dose	Freq.	Pharmacy POD check			One Stop Dispensing					
					Amount	Date	Sig.	Date	Sig.	Qty	Date	Sig.	Qty

I have listed the PODs above and received consent for their use. I will check any POD I need to administer to the patient before pharmacy have seen and approved their use against the criteria for suitability of use in the Hinchingbrooke policy for the reuse of PODs.

Pharmacist / Pharmacy Tech / Nurse / Midwife Name: ____________________ **Signature:** ______________ **Date:** ________