M 1.4

PRN Blister Pack

Administration and Authority Record

Name:
Address:

D.O.B:

MEDICATION NAME:	DOSE:	ROUTE OF ADMINISTRATION:
CONDITIONS FOR USE: *(Specific, observable, behavioural description of when to use)*		
Maximum dose to be given in a specified period:		
Minimum time between each dose:		
COMMENTS/REASON PRESCRIBED:	DATE COMMENCED:	DATE CEASED:
	Date consent sought	Doctors signature

Date															
Time															
Is the medication for the correct person?															
Does the medication contents match the Medication authority?															
Have the specific conditions for use been met?															
Is the medication being given within the minimum time between doses and the maximum dose as specified above?															
Is the medication in good condition within the expiry date?															
Authorization to administer has been obtained ?															
Total dose given (e.g. 500mgs)															
Is the route and conditions of administration correct?															
Did you see the medication administered correctly?															
Total Number of tablets remaining in active package															
Initials															