M 1.5

Non-Blister Pack Medication Administration and Authority Record

Name:
Address:

D.O.B:

MEDICATION NAME:					TOTAL DAILY DOSE:	ROUTE:
Time/s of Administration					DATE COMMENCED:	DATE CEASED:
Dose/volume to be Administered					Date consent sought	Doctors signature
REASON PRESCRIBED & DIRECTIONS FOR USE:						
MINIMUM TIME BETWEEN EACH DOSE (PRN ONLY):					MAXIMUM DOSE IN A GIVEN PERIOD (PRN ONLY):	
CONDITIONS FOR USE (PRN ONLY): Specific and observable description of when to use PRN						

Date																			
Time																			
Is the medication the correct name, time & day?																			
Does the medication label match the Authority above?																			
Was previous medication recorded as administered?																			
Are the medications in good condition within expiry date?																			
Amount of medication administered (Volume).																			
Is the route and conditions of administration correct?																			
Was the medication administered correctly?																			
Was authorization obtained? (PRN medication only)																			
Initials																			

Date																			
Time																			
Is the medication the correct name, time & day?																			
Does the medication label match the Authority above?																			
Was previous medication recorded as administered?																			
Are the medications in good condition within expiry date?																			
Amount of medication administered (Volume).																			
Is the route and conditions of administration correct?																			
Was the medication administered correctly?																			
Was authorization obtained? (PRN medication only)																			
Initials																			