National Residential Medication Chart v.4

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

ALERT
Consumer with similar name?
Y / N

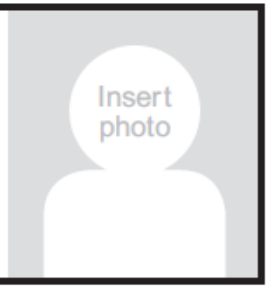
Consumer name

Preferred name

Date of Birth / / Gender Photo date / /

URN/MRN IHI

RACS ID RACF name



CONSIDERATIONS

Swallowing difficulties	Y / N
Cognitive impairment	Y / N
Dexterity difficulties	Y / N
Resistive to medicine	Y / N
Nil by mouth	Y / N
Self administers	Y / N
Other	Y / N

Details if Y to above: _____

Non packed medicines ☐

ALERT: Complex medications

Variable dose Y / N
Insulin Y / N
Other Y / N (specify): _____

Medicare number

Pension number

DVA number

PRIMARY GENERAL PRACTITIONER

Name
Address
Phone Fax
Out of hours
Prescriber number
Email

Signature

PRESCRIBER details (if not primary GP)

Name
Address
Phone Fax
Out of hours
Prescriber number
Email

Signature

PRESCRIBER details (if not primary GP)

Name
Address
Phone Fax
Out of hours
Prescriber number
Email

Signature

PRESCRIBER details (if not primary GP)

Name
Address
Phone Fax
Out of hours
Prescriber number
Email

Signature

Chart commenced ___/___/___ Expiry date ___/___/___
Review date ___/___/___

Maximum chart validity is 4 months from the date the chart is commenced

PHARMACY

Name
Phone Fax
Email

RACF Name

RACF Address

Chart ____ of ____

Front page MUST be sent to pharmacy on each change

Regular medicine

Month 1: Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Sign in this section for multi-dose delivery (eg. multi-dose packs)

Date / Times	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Breakfast																															
Lunch																															
Dinner																															
Bed time																															

Month 1

Sign in this section for individual medicine administration

Date / Times	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Month 1

Start date ___/___/___

Stop date

☐ Valid for duration of chart

OR

Stop date ___/___/___

1. Medicine/form/strength

.....

.....

.....

Additional instructions

.....

Dose

Route

Frequency

Non packed ☐

PBS/RPBS Streamlined authority code ☐☐☐☐☐

CTG ☐ Brand substitution not permitted ☐

Prescriber signature and name

Date of prescribing ___/___/___