

# ADDRESSOGRAPH

Surname: \_\_\_\_\_

First Names: \_\_\_\_\_

Date of Birth:      /      /

Hospital Number: \_\_\_\_\_

NHS Number: \_\_\_\_\_

Date of Admission

Weight (kg)

Height (cm)

BSA (m<sup>2</sup>)

/ /

□	□	□
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□	□	□
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□	.	□	□
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# Allergies

Allergy

Reaction Type

COMPLETE BEFORE DRUG ADMINISTRATION

## PRESCRIPTION CHART INFORMATION

Ward: \_\_\_\_\_

Consultant: \_\_\_\_\_

Pharmacy Cost Centre: \_\_\_\_\_

Chart rewritten by: \_\_\_\_\_

Date:      /      /      Chart No:  of

## ADMISSION CHECKLIST - complete on clerking

1. Has a venous thromboembolism (VTE) risk assessment been completed?    Yes     No     If not, why? \_\_\_\_\_

Yes     No     If not, why? \_\_\_\_\_

2. Has the indication and suggested length of treatment been documented for all **antibiotics**?

Yes     No     If not, why? \_\_\_\_\_

3. Have **allergies** and **reaction** type been documented?

Admitting Doctor Name \_\_\_\_\_

Admitting Doctor Signature \_\_\_\_\_

## ONCE ONLY MEDICINES

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber's Signature	Time Given	Given By	Pharmacy

Contents

3

Anti-thrombotics  
Insulin sliding scale  
Oxygen

5

Anti-infectives  
Regular prescriptions

11

As required prescriptions

13

Infusions

Back

Medicine reconciliation

Variable dose prescriptions



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# Allergies

Allergy	Reaction Type

COMPLETE BEFORE DRUG ADMINISTRATION

## ANTI-INFECTIVE AGENTS

Prescriber to review every third day and initial in red outlined box

MEDICINE (Approved name) \_\_\_\_\_

Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Day #	1	2	3	4	5	6	7	8	9	10	11	12	13	14
08														
12														
18														
22														

D O S E     microgram mg g units Other

OD BD TDS QDS Other     Route

Indication     Duration

Name     Signature     Bleep

Additional information     Pharmacist Initials

MEDICINE (Approved name) \_\_\_\_\_

Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14
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 Weight (kg)     □ □ □     Height (cm)     □ □ □     BSA (m<sup>2</sup>)     □ . □ □

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COMPLETE BEFORE DRUG ADMINISTRATION

REGULAR PRESCRIPTIONS		Date:												
MEDICINE (Approved name)														
EXAMPLE		08												
D O S E    microgram mg g units Other		12												
1 5 0    microgram mg g units Other		18												
OD BD TDS QDS Other    Route		22												
OD BD TDS QDS Other    Route														
PO														
Name    Signature    Bleep														
A. Doctor <i>[Signature]</i> 4528														
New <input checked="" type="checkbox"/> Start date    Additional information    Pharmacist Initials														
31/03    After food    A. Name														
MEDICINE (Approved name)		08												
		12												
D O S E    microgram mg g units Other		18												
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 Height (cm)     □   □   □  
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## AS REQUIRED PRESCRIPTIONS

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D O S E <b>microgram mg g units Other</b>															
Max Frequency	Route	Indication													
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## MEDICINE RECONCILIATION

GP contact details

Carer's contact details

Compliance aids in use

Source of medication history: Patient  GP  PODS  TTA  Carer  Other:

### MEDICINES NORMALLY TAKEN AT HOME

Medicine	Dose	Frequency

### CHANGES IN THERAPY SINCE ADMISSION

Withheld	Stopped	Dose changed to	Reason for change
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		
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<input type="checkbox"/>	<input type="checkbox"/>		

Checked by: Name  Date

EDC written by: Name  Date

Chart transcription checked by: Name  Date

## COMMUNICATIONS TO TEAM

## SMARTPHONE LINKS

Adult BNF



Paediatric BNF



Anti-biotic guidelines



Prescription chart user guide & feedback

