Health
South Eastern Sydney
Local Health District

NSW GOVERNMENT

Facility:

COMMUNITY MEDICATION AUTHORISATION & RECORD

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ______ / ______ / ______	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

1st Prescriber to Print Patient Name & Check Label Correct:

....

***Original MUST be sent home with patient**

SES130020

BINDING MARGIN - NO WRITING

Holes punched as per AS2828.1:2012

ALLERGIES & ADVERSE DRUG REACTIONS (ADR) ☐ Nil Known ☐ Unknown

Drug (or other)	Reaction / Type / Date	Initials	Drug (or other)	Reaction / Type / Date	Initials

In the event of an anaphylactic reaction administer Adrealine 1:1000
0.3 mg – 0.5mg (0.3mls – 0.5mls) by intramuscular injection as per local hospital policy

Medication (Print Generic Name)		Medication (Print Generic Name)	
Dose	Fluid (IV Only)	Dose	Fluid (IV Only)
Route	Volume (IV Only)	Route	Volume (IV Only)
Frequency	Rate (IV Only)	Frequency	Rate (IV Only)
Indication	Start Date	Indication	Start Date
Special Instructions	Completion Date	Special Instructions	Completion Date
MO Signature	Date Ordered	MO Signature	Date Ordered
MO Name (Print)	MO Contact No.	MO Name (Print)	MO Contact No.

Date	Time	RN Signature	Date	Time	RN Signature

S0168 220213

COMMUNITY MEDICATION AUTHORISATION & RECORD SES130.020

NO WRITING