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	Health					'NAME	MRN						
	South Eastern Sydney GOVERNMENT Local Health District				GIVEN	NAME	☐ MALE ☐	FEMALE					
SES130020	Facility:				D.O.B.			M,O,					
						ADDRESS							
	COMM	COMMUNITY MEDICATION											
	AUTHORISATION & RECORD					LOCATION / WARD							
						COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE							
						1st Prescriber to Print Patient Name & Check Label Correct:							
	*Original MI	UST	be sent home	e with patient									
	ALLERGI	FS &	ADVERSE D	RUG REACTIONS (	ADR)		Knowi	^	Unknown				
	Drug (or other		Type / Date	Initials	Drug (or othe	- 7	Reaction / T		Initials				
		.,		.ypo / Date			,		<b>,</b>				
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	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)							
NO WRITING	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				
T	Special Instructions			Completion Date		Special Instructions			Completion Date				
ARGIN	MO Signature			Date Ordered		MO Signature			Date Ordered				
IG MA	MO Name (Print)			MO Contact No.		MO Name (Print)			MO Contact No.				
BINDING	Date		Time	RN Signatu	ire	Date		Time	RN Signa	ature			
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Dose		Fluid (IV Only)	Dose		Fluid (IV Only)		
Route		Volume (IV Only)	Route		Volume (IV Only)		
Frequency Indication Special Instructions MO Signature MO Name (Print)		Rate (IV Only)	Frequency		Rate (IV Only)		
		Start Date	Indication		Start Date		
		Completion Date	Special Instruc	ctions	Completion Date  Date Ordered		
		Date Ordered	MO Signature				
		MO Contact No.	MO Name (Pri	nt)	MO Contact No.		
Date	Time	RN Signature	Date	Time	RN Signature		
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