

Chart \_\_ of \_\_ in use The Children's Hospital NHS Trust

## Medication chart

First name:  Hospital number:

Surname:  NHS number:

Date of birth:  Address:

**Allergies:**

Signed:  Date:

Admission date:  Chart start date:  Weight:

## Single-dose prescriptions

| Date | Time | Drug name | Dose | Route | Signature |
|------|------|-----------|------|-------|-----------|
|      |      |           |      |       |           |
|      |      |           |      |       |           |
|      |      |           |      |       |           |
|      |      |           |      |       |           |
|      |      |           |      |       |           |
|      |      |           |      |       |           |

|       |      |                  |
|-------|------|------------------|
| Name: | DOB: | Hospital number: |
|-------|------|------------------|

**Regular medications**

| Dose                | Route |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---------------------|-------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Frequency           |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Start date          |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Duration            |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Signature and bleep |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                     |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

| Dose                | Route |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---------------------|-------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Frequency           |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Start date          |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Duration            |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Signature and bleep |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                     |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

| Dose                | Route |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---------------------|-------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Frequency           |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Start date          |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Duration            |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Signature and bleep |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                     |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|       |      |                  |
|-------|------|------------------|
| Name: | DOB: | Hospital number: |
|-------|------|------------------|

**As required medications**

| Dose              | Route |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|-------------------|-------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Maximum frequency |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Indication        |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Sign              |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Bleep             |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

| Dose              | Route |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|-------------------|-------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Maximum frequency |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Indication        |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Sign              |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Bleep             |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

| Dose              | Route |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|-------------------|-------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Maximum frequency |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Indication        |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Sign              |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Bleep             |       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Name:

DOB:

Hospital number:

### Intravenous or subcutaneous infusions

| Date | Route | Fluid | Volume | Rate | Drug/additive | Dose | Sign |
|------|-------|-------|--------|------|---------------|------|------|
|      |       |       |        |      |               |      |      |
|      |       |       |        |      |               |      |      |
|      |       |       |        |      |               |      |      |
|      |       |       |        |      |               |      |      |
|      |       |       |        |      |               |      |      |
|      |       |       |        |      |               |      |      |
|      |       |       |        |      |               |      |      |
|      |       |       |        |      |               |      |      |
|      |       |       |        |      |               |      |      |