NHS Blackpool Teaching Hospitals NHS Foundation Trust

WARD	HOSPITAL	
CONSULTANT		
DATE OF ADMISSION	WEIGHT	HEIGHT
DATE WRITTEN CHART ..... of	DATE REWRITTEN	

Write patient details or affix Identification label

Hospital Number:
Name:
Address:

Date of Birth:
NHS Number:

HAS THE VTE RISK ASSESSMENT FORM BEEN COMPLETED? ■ PLEASE TICK.

ALLERGY STATUS should be confirmed and documented prior to medication being prescribed. Please indicate if there are no known allergies i.e. NKA

Allergy or Sensitivity to:	Type of Reaction (eg. rash)
Name: Signature:	Date:

Please tick if the patient has any of the following:
Clostridium difficile ■, MRSA ■, MSSA ■

ONCE-ONLY and PRE-MEDICATION

Date Required	Time Required	Drug	Route	Dose	Prescriber's Signature and Bleep	Given by	Checked by	Date Given	Time Given

OXYGEN (See CORP/GUID/312 for guidance) Continual review as per POTTS Chart

YEAR / DATE/MONTH ⬇ / TICK OR INSERT TIMES REQUIRED ⬇																
CIRCLE TARGET OXYEN SATURATION																
94-98%																
88-92% (IF AT RISK OF TYPE II RESPIRATORY FAILURE)	MORNING															
OTHER	MIDDAY															
STARTING DEVICE/FLOW RATE																
PRN/CONTINUOUS	EVENING															
TICK HERE IF SATURATION NOT INDICATED ☐	BEDTIME															
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY) / BLEEP																
START DATE / STOP DATE																

Device Code: Venturi Mask (**VM%**); Simple Face Mask (**SFM**); Humidified (**H%**); Non-rebreathing Mask (**NRB**); Nasal Cannulae (**NC**); Humidified via Trache Mask (**TM%**)

Antimicrobials should be prescribed in accordance with the Antimicrobial Formulary

ANTIBIOTICS ONLY

INSERT TIMES REQUIRED

48 Hour review (Printed Name/ Required)

DRUG				DATE
DOSE	ROUTE	START DATE	STOP DATE	
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)		GMC Number	BLEEP	
INDICATION	SENSITIVITIES: Y/N	MICRO APPROVED: Y/N		
ADDITIONAL INFORMATION		PHARMACY		

DRUG				DATE
DOSE	ROUTE	START DATE	STOP DATE	
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)		GMC Number	BLEEP	
INDICATION	SENSITIVITIES: Y/N	MICRO APPROVED: Y/N		
ADDITIONAL INFORMATION		PHARMACY		

DRUG				DATE
DOSE	ROUTE	START DATE	STOP DATE	
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)		GMC Number	BLEEP	
INDICATION	SENSITIVITIES: Y/N	MICRO APPROVED: Y/N		
ADDITIONAL INFORMATION		PHARMACY		

DRUG				DATE
DOSE	ROUTE	START DATE	STOP DATE	
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)		GMC Number	BLEEP	
INDICATION	SENSITIVITIES: Y/N	MICRO APPROVED: Y/N		
ADDITIONAL INFORMATION		PHARMACY		

DRUG				DATE
DOSE	ROUTE	START DATE	STOP DATE	
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)		GMC Number	BLEEP	
INDICATION	SENSITIVITIES: Y/N	MICRO APPROVED: Y/N		
ADDITIONAL INFORMATION		PHARMACY		

Prescriptions for intravenous antibiotics must be reviewed after 24-48 hours. Switch to oral as soon as possible. All Antibiotics are valid for 5 days only.

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CONSULTANT	
DATE OF ADMISSION	WEIGHT	HEIGHT
DATE WRITTEN CHART .... of	DATE REWRITTEN

Write patient details or affix Identification label

Hospital Number:
Name:
Address:

Date of Birth:
NHS Number:

HAS THE VTE RISK ASSESSMENT FORM BEEN COMPLETED? ■ PLEASE TICK.

REGULAR

YEAR DATE/MONTH ➔

TICK OR INSERT TIMES REQUIRED ➔

DRUG: **DALTEPARIN**		
DOSE	ROUTE: S/C	START DATE / STOP DATE
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)	BLEEP	
ADDITIONAL INFORMATION	PHARMACY	

MORNING / MIDDAY / EVENING / BEDTIME

DRUG: **ANTI-EMBOLISM STOCKINGS**		
DOSE	ROUTE	START DATE / STOP DATE
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)	BLEEP	
ADDITIONAL INFORMATION	PHARMACY	

MORNING / MIDDAY / EVENING / BEDTIME

DRUG		
DOSE	ROUTE	START DATE / STOP DATE
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)	BLEEP	
ADDITIONAL INFORMATION	PHARMACY	

MORNING / MIDDAY / EVENING / BEDTIME

DRUG		
DOSE	ROUTE	START DATE / STOP DATE
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)	BLEEP	
ADDITIONAL INFORMATION	PHARMACY	

MORNING / MIDDAY / EVENING / BEDTIME

DRUG		
DOSE	ROUTE	START DATE / STOP DATE
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)	BLEEP	
ADDITIONAL INFORMATION	PHARMACY	

MORNING / MIDDAY / EVENING / BEDTIME

DRUG		
DOSE	ROUTE	START DATE / STOP DATE
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)	BLEEP	
ADDITIONAL INFORMATION	PHARMACY	

MORNING / MIDDAY / EVENING / BEDTIME

REGULAR

YEAR

DATE/MONTH ▶

TICK OR INSERT TIMES REQUIRED ⬇

DRUG				
DOSE	ROUTE	START DATE	STOP DATE	MORNING
				MIDDAY
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)			BLEEP	EVENING
				BEDTIME
ADDITIONAL INFORMATION			PHARMACY	

DRUG				
DOSE	ROUTE	START DATE	STOP DATE	MORNING
				MIDDAY
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)			BLEEP	EVENING
				BEDTIME
ADDITIONAL INFORMATION			PHARMACY	

DRUG				
DOSE	ROUTE	START DATE	STOP DATE	MORNING
				MIDDAY
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)			BLEEP	EVENING
				BEDTIME
ADDITIONAL INFORMATION			PHARMACY	

DRUG				
DOSE	ROUTE	START DATE	STOP DATE	MORNING
				MIDDAY
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)			BLEEP	EVENING
				BEDTIME
ADDITIONAL INFORMATION			PHARMACY	

DRUG				
DOSE	ROUTE	START DATE	STOP DATE	MORNING
				MIDDAY
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)			BLEEP	EVENING
				BEDTIME
ADDITIONAL INFORMATION			PHARMACY	

DRUG				
DOSE	ROUTE	START DATE	STOP DATE	MORNING
				MIDDAY
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)			BLEEP	EVENING
				BEDTIME
ADDITIONAL INFORMATION			PHARMACY	

AS REQUIRED

DRUG			INDICATION	
DOSE	ROUTE	FREQUENCY	MAXIMUM IN 24 HOURS	
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)			DATE	BLEEP
ADDITIONAL INFORMATION				PHARMACY

DRUG			INDICATION	
DOSE	ROUTE	FREQUENCY	MAXIMUM IN 24 HOURS	
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)			DATE	BLEEP
ADDITIONAL INFORMATION				PHARMACY

DRUG			INDICATION	
DOSE	ROUTE	FREQUENCY	MAXIMUM IN 24 HOURS	
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)			DATE	BLEEP
ADDITIONAL INFORMATION				PHARMACY

DRUG			INDICATION	
DOSE	ROUTE	FREQUENCY	MAXIMUM IN 24 HOURS	
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)			DATE	BLEEP
ADDITIONAL INFORMATION				PHARMACY

DRUG			INDICATION	
DOSE	ROUTE	FREQUENCY	MAXIMUM IN 24 HOURS	
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)			DATE	BLEEP
ADDITIONAL INFORMATION				PHARMACY

DRUG			INDICATION	
DOSE	ROUTE	FREQUENCY	MAXIMUM IN 24 HOURS	
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)			DATE	BLEEP
ADDITIONAL INFORMATION				PHARMACY

DRUG			INDICATION	
DOSE	ROUTE	FREQUENCY	MAXIMUM IN 24 HOURS	
PRESCRIBER'S SIGNATURE (ALSO PRINT NAME CLEARLY)			DATE	BLEEP
ADDITIONAL INFORMATION				PHARMACY

DATE	TIME	DOSE	ROUTE	Given / Checked	DATE	TIME	DOSE	ROUTE	Given / Checked	DATE	TIME	DOSE	ROUTE	Given / Checked

ANTICOAGULANT TREATMENT (See CORP/GUID/310) EXISTING / NEW PATIENT

Anticoagulant book issued ☐ Counselling provided ☐ By..... Date.....

Surname..... First Name .....

.....

Hosp. No. ..... Diagnosis/indication .....

Anticoagulant..... Date Started.....

Duration of Treatment ..... Desired Range of INR .....

Date	INR	Dosage mg / day	Prescriber's Signature (also print name clearly)	Bleep	Date	INR	Dosage mg / day	Prescriber's Signature (also print name clearly)	Bleep

NON-ADMINISTRATION OF MEDICINES (see CORP/PROC/307)

WHEN THE PATIENT DOES NOT RECEIVE THE PRESCRIBED DOSE, THE NURSE MUST ENTER A NON-ADMINISTRATION CODE. INFORM DOCTOR IF DRUG OMITTED.

1. Patient refused
2. Patient away from ward
3. Patient unable to receive medicines/or no access medicines/or no access
4. Nil by mouth
5. Medicine unavailable (attempt to obtain failed)
6. Self-administered
7. Other reason – see notes

INSTRUCTIONS FOR USE

- Sign and print your name clearly against each prescription
- Use APPROVED DRUG NAME and print each entry **LEGIBLY IN CAPITAL LETTERS** in **Black indelible ink.**
- Do not use abbreviation of drug names. Always write units and micrograms in full.
- NEVER alter existing instructions – **write a new entry.**
- When drugs are discontinued draw a diagonal line through the drug name and administration sections. Date and sign cancellation.
- All antibiotic prescriptions MUST have an indication and stop/review date.
- Additional advice available in Prescribing Medicines CORP/PROC/301.

Pharmacists - note any significant intervention/pharmaceutical care problem	Insert ✓ to indicate checks or assessments completed Sig/Date	
	Drug history checked/medicines reconciled Sig/Date/Time ☐	Details of admission medication:- (Please note problems/omissions)
	Allergy status checked Sig/Date ☐	
	Drug rewrite checked Sig/Date ☐	
	PODs checked Sig/Date ☐	
	TTO completed Sig/Date ☐	
	Compliance aid in use NO / YES	