QR Code

Children's Community Service **Outpatient Prescription** Noble's Hospital Children's Ward Strang, Braddan, Isle of Man, IM4 4RJ

Patient name:

DOB:

Hospital Number:

Please affix patient ID label

IF NO KNO	OWN ALLE	RGIES	SIGN AN	ID DAT	E ON THIS	LINE:												
Drug Sensi	tivities and	Allergie	es						Disch	arged fro	m:							
	Orug (s)			tion of I	Reaction	Signat	ure & Date		Consi	ultant:								
							General Pra					Practitioner:						
							Primary Nurse (Community):											
													1					
								_		rt No.								
S	hould allerg	y or we	eight be u	pdated-	please do	so on ALL	pages	_	Star	t Date								
Date:																		
Weight (k	g):																	
					ONC	ONLY P	RESCRIP	TIONS	STAT	Dosing)								
Date	Time			Drug		Dose	Route			riber's Sig		re	Date	Time	Given by			
							Double check	_				ust sign and nt Check here.	Pharmacy si	gnature:	'			
										ing hospital. S		ust sign and nt Check here.	Pharmacy si	gnature:				
							Double check	_				ust sign and nt Check here.	Pharmacy si	gnature:				
							Double check					ust sign and nt Check here.	Pharmacy si	gnature:				
	Double check all witness the corre											Pharmacy si	gnature:					
							Double check					ust sign and nt Check here.	Pharmacy si	gnature:				
	does not recei																	
1. Refused	Drug not av	ailable	Prescri	ption not	clear 4. Adn	ninistration r	oute not ava	ailable										

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Children's Community Outpatient Prescription

Owner: Children's Community Service Review: Patient Safety & Quality Committee Printed: _____ Review:

Drug Allergies:	
Weight (kg):	

Topically Rectally Vaginally

TOP PR PV

Subcutaneous Intra-muscular Intravenously

atient	name:
OR.	

Hospital Number:

Please affix patient ID label

NG PEG JEJ	PO	SC SC	IM	IV										
			WHEN R	EQUIRE	D MED	OICATI	ON							
Drug:				Date of										
Dose:		Maximum Daily Dose:		Time of administration										
Route:		Type of IV line (if applic	able):											
Indication:		Duration of Treatment:												
Signature:		Pharmacy Review:												
Print name:														
Date:	7	Other instructions:					V	<u>/</u>	V	V	V	V	V	
F	OR INTR	AVENOUS AND SUB	CUTANEOUS MEI	MEDICATIONS ONLY (SEEK PHARMACY ADVICE PRIOR TO PRESCRIBING)										
Diluent:	iluent: Diluent volume: Volume of reconstitu				to adminis	ter:	Duration	of adminis	tration:		Flush with medication):	n (please prescr	ibe as a when re	quired
Double check all drugs before leaving hosassembled [should be labelled patient sp				tions are			,							
Descri				Date of			1							
Drug:				administration										
Dose:		Maximum Daily Dose:		Time of administration										
Route:		Type of IV line (if ap	oplicable):											
Indication:		Duration of Treatm	ent:											
Signature:		Pharmacy Review:												
Print name:														
Date:		Other instructions:											,	
F	OR INTR	AVENOUS AND SUB	CUTANEOUS MED	DICATIONS	ONLY (SE	EK PHARI	MACY AD	VICE PRIC	OR TO PR	ESCRIBING	G)			
Diluent: Diluent volume: Volume of record					ion to adm	inister:	Duration	of adminis	tration:		Flush with medication):	n (please prescr	ibe as a when re	quired
Double check all drugs before leaving hosassembled [should be labelled patient sp	-	_		tions are										
·	Vhen child does not receive a prescribed dose, the nurse must enter a reason for non-administration code. Please attempt to obtain any unavailable medicines. Refused 2. Drug not available 3. Prescription not clear 4. Administration route not available													

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Percutaneous endoscopic

Jejunostomy

Oral

Nasogastric

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Owner: Children's Community Service Review: Patient Safety & Quality Committee Printed: ______ Review: ______

Drug Allergi	es:			
Weight (kg)	:			
	Ton	ically	Poetally	Vaginally

ТОР PV

atient	name:
OB.	

Hospital Number:

Please affix patient ID label

Percutaneous Nasogastric endoscopic Jejunostomy gastrostomy	Oral Subcutaneous Intra-muscular	Intravenou	ısly										
NG PEG JEJ	PO SC IM	IV											
	WHE	N REQUIRE	D MED	DICATI	ON								
Drug:		Date of ———————————————————————————————————											
Dose:	Maximum Daily Dose:	Time of administration ▼											
Route:	Type of IV line (if applicable):												
Indication:	Duration of Treatment:												
Signature:	Pharmacy Review:												
Print name:													
Date:	Other instructions:			<i>V</i>	V	V		V		/l			
FOR INTRAVENOUS AND SUBCUTANEOUS MEDICATIONS ONLY (SEEK PHARMACY ADVICE PRIOR TO PRESCRIBING)													
Diluent: Diluent	volume: Volume of reco	onstituted solution	to adminis	ter:	Duration	of adminis	tration:) (please prescri	be as a when re	quired	
									medication):				
Double check all drugs before leaving hospital. assembled [should be labelled patient specific]					\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \								
assembled [should be labelled patient specific] . Document check here. (Nurse's Signature)													
D		Date of —											
Drug:	<u> </u>	administration											
Dose:	Maximum Daily Dose:	Time of administration											
Route:	Type of IV line (if applicable):												
Indication:	Duration of Treatment:												
Signature:	Pharmacy Review:												
Print name:													
Date:	Other instructions:												
FOR IN	ITRAVENOUS AND SUBCUTANEOUS	MEDICATIONS	ONLY (SE	EK PHAR	MACY AD	VICE PRIC	R TO PR	ESCRIBING	G)				
Diluent: Dil	uent volume: Volume of r	reconstituted solut	tion to adm	inister:	Duration	of adminis	tration:		Flush with medication):	1 (please prescri	be as a when re	quired	
Double check all drugs before leaving hospital. assembled [should be labelled patient specific]													
When child does not receive a prescribed dose	When child does not receive a prescribed dose, the nurse must enter a reason for non-administration code. Please attempt to obtain any unavailable medicines.												
1. Refused 2. Drug not available 3. Prescripti	Refused 2. Drug not available 3. Prescription not clear 4. Administration route not available												

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Review:

Drug Allergies:			
Weight (kg):			
	Topically	Rectally	Vaginally
	TOP	PR	PV

Patient name: DOB: Hospital Number:

Please affix patient ID label

					104	PK	PV
Nasogastric	Percutaneous endoscopic gastrostomy	Jejunostomy	Oral	Subcutaneous	Intra-muscular	Intrave	nously
NG	PFG	IFI	PO	SC	IM	IN.	,

NG	PEG	JEJ	PC	S	с	IM	IV										
						REGULARLY	PRESCR	IBED I	MEDIC	ATION							
Drug:							Date of										
Dose:				Maximum Daily Dose:			Time of administration										
Route:				Type of IV lin	e (if appl	icable):											
Indication:				Duration of T	reatmen	t:											
Signature:				Pharmacy Re	view:												
Print name:																	
Date:				Other instruc	ctions:				/				V	V	V	V	V
FOR INTRAVENOUS AND SUBCUTANEOUS MEDICATIONS ONLY (SEEK PHARMACY ADVICE PRIOR TO PRESCRIBING)																	
Diluent:			Diluent vol	lume:		Volume of reconstit	uted solution	to adminis	ter:	Duration	of administ	ration:		Flush wit	h (please presci	ibe as a when re	quired
														medication).			
						ss the correct medica (Nurse's Signature)	ations are										
							→										
Drug:							Date of										
Dose:				Maximui Daily Dos			Time of administration										
Route:				Type of I	V line (if a	applicable):											
Indication:				Duration	of Treatr	ment:											
Signature:				Pharmac	y Review	:											
Print name:																	
Date:				Other ins	structions	s:											
			FOR INTR	AVENOUS A	AND SUE	BCUTANEOUS ME	DICATIONS (ONLY (SE	EK PHARI	MACY AD	VICE PRIC	R TO PR	ESCRIBIN	G)			
Diluent:			Diluen	t volume:		Volume of recor	nstituted solut	ion to adm	inister:	Duration	of adminis	tration:		Flush wit	h (please presci	ibe as a when re	equired
Double check all drugs before leaving hospital. Staff must sign and witness the correct med assembled [should be labelled patient specific] . Document check here. (Nurse's Signature)							ations are										
						eason for non-admin		. Please at	empt to o	btain any u	ınavailable	medicines	i.	E	5		
1. Kerused 2	rug not ava.	nable 3. Pr	escription i	not clear 4.	Aaminist	ration route not avai	iiabie										

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				Drug Allergies:				
m	XIDX Kiarail		Topically	Rectally	Vaginally			
					TOP	PR	PV	
Nasogastric	Percutaneous endoscopic	Jejunostomy	Oral	Subcutaneous	Intra-muscular	Intravenously		
NG	PEG	JEJ	PO	sc	IM	IV.	,	

Patient name:

DOB:

Hospital Number:

Please affix patient ID label

NG PEG JEJ	PO	SC	IM	IV										
			REGULARLY	PRESCR	RIBED I	MEDIC	ATION							
Drug:				Date of										
Dose:		Maximum Daily Dose:		Time of administration										
Route:	Т	Type of IV line (if applic	cable):											
Indication:	С	Ouration of Treatment:												
Signature:	P	Pharmacy Review:												
Print name:														
Date:	C	Other instructions:				,	<i>V</i>			<i>V</i>		~		
F	OR INTRA	AVENOUS AND SUB	CUTANEOUS MEI	DICATIONS	ONLY (SE	EK PHAR	MACY AD	VICE PRIC	OR TO PR	ESCRIBIN	G)			
Diluent: D					to adminis	ter:	Duration	of adminis	tration:		Flush with medication):	n (please prescr	ibe as a when re	quired
Double check all drugs before leaving hos assembled [should be labelled patient spe				tions are			7							
Drug:				Date of administration										
Dose:		Maximum Daily Dose:		Time of administration										
Route:		Type of IV line (if a	pplicable):											
Indication:		Duration of Treatm	nent:											
Signature:		Pharmacy Review:												
Print name:														
Date:		Other instructions:					<i>V</i>						,	
FC	OR INTRA	AVENOUS AND SUB	CUTANEOUS MEI	DICATIONS	ONLY (SE	EK PHARI	MACY AD	VICE PRIC	OR TO PR	ESCRIBING	G)			
Diluent: Diluent volume: Volume of recor					ion to adm	inister:	Duration	of adminis	tration:		Flush with medication):	n (please prescr	ibe as a when re	quired
Double check all drugs before leaving hos assembled [should be labelled patient spe		ations are												
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