HSS Medication Authority

Ph: 1800 854 300 Fax: 1800 854 611
Email: hss@hss.com.au

home support services

MANDATORY: RING HSS TO CHECK MEDICATION PRIOR TO ADMINISTRATION RING: 1800 613 909

8 Rights' of Medication

1. **Right client**
2. **Right dose**
3. **Right route**
4. **Right reason**
5. **Right drug**
6. **Right time**
7. **Right documentation**
8. **Right response**

Patient Surname Given Names D.O.B

Address State Post Code

Phone Number Mobile Treating Dr

MEDICATION ALERT (Allergies)

PICC Insitu ☐ Yes ☐ No Date of Last Dressing Portacath ☐ Yes ☐ No Needle Size Cannulated ☐ Yes ☐ No

FREQUENCY TO INDICATE IF 24HR INFUSOR / DAILY INFUSION / PUSH / STAT DOSE

Medication (Generic Name)	Dose	Date / Time / RN Sign
Start Date / Cease Date	Route	
Dr Signature		Date / Time / RN Sign
Dr Name	Frequency	
Date		

Medication (Generic Name)	Dose	Date / Time / RN Sign
Start Date / Cease Date	Route	
Dr Signature		Date / Time / RN Sign
Dr Name	Frequency	
Date		

Medication (Generic Name)	Dose	Date / Time / RN Sign
Start Date / Cease Date	Route	
Dr Signature		Date / Time / RN Sign
Dr Name	Frequency	
Date		

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