HSS MEDICATION AUTHORITY

Ph: 1800 854 300 Fax: 1800 854 611

HSS home support services
homehospitalcare

Patient Surname ____________ Given Names ____________ D.O.B ___ / ___ / ___

Patient Address ________________________________

State ________ Post Code ________ Phone Number ________

MEDICATION ALERT (Allergies) ________________________________

PICC Insitu ☐ Yes ☐ No Date of Last Dressing ________ Cannulated ☐ Yes ☐ No

5 Rights' of Medication

1. Right method
2. Right person
3. Right medication
4. Right dose
5. Right Time/ Date / Day

Mandatory:
Check med before admin
Ring: 1800 613 909

Medication		Dose
Start Date	Cease Date	Route
Dr Signature		
		Frequency
Dr Name		
Date		

	Dates													
Times														

	Dates													
Times														

	Dates													
Times														

Medication		Dose
Start Date	Cease Date	Route
Dr Signature		
		Frequency
Dr Name		
Date		

	Dates													
Times														

	Dates													
Times														

	Dates													
Times														

Medication		Dose
Start Date	Cease Date	Route
Dr Signature		
		Frequency
Dr Name		
Date		

	Dates													
Times														

	Dates													
Times														

	Dates													
Times														

Medication		Dose
Start Date	Cease Date	Route
Dr Signature		
		Frequency
Dr Name		
Date		

	Dates													
Times														

	Dates													
Times														

	Dates													
Times														