# Logo.jpg

****

**Nominated agency representative to**

**transfer when needed – only if no change in medication**

**Signed ……………………………………..**

**Medicines Administration Record for medication not in an MDS**

**A. SECTION FOR DOCTOR/HEALTHCARE PROFESSIONAL(HCP)TO FILL IN (one form required for each medication)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patient’s name & address:** | | | | | **dob** |
| **Doctor’s Name and Signature (or HCP if nominated by Doctor)** | | | | | **Date** |
| **Doctor’s address and telephone number:** | | | | | |
| Medication, Drug, strength & form | Dose and Frequency  **‘PRN or as directed is not sufficient’** | Purpose | Date to start | Date to end **(please indicate whether)**  **Stop or Review Date** | |
|  |  |  |  |  | |

1. **SECTION FOR CARER**
2. You may only administer the medication if all the above is completed. If it is a Level 3 or Level 4 task then you may only administer after receiving training from the District Nurse or GP and this must be recorded on the TAC form in the provider/client care plan in the client’s home.
3. Please fill in the dates of assistance at the top of each narrow column.
4. Please administer the medication at the times indicated and initial the box. If the medicine is not given for any reason please write administration code in the signature box and reason why on page 2 of the form.
5. **Service provider manager may transfer (photocopy only) current form only if stop or review date of medication is current.**R = refused S = sleeping O =other (record in care plan)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date/Day: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Breakfast |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Lunch |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Tea |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Bedtime |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Page 1 of 2Medicines Administration Record not in an MDS January 2011

Abbreviation: (MDS – Monitored Dosage System)

## Social & Community Services Logo.jpg

## IIPLOGO

## CARE WORKER OR PERSON ASSISTING THE CLIENT WITH THEIR MEDICATION

## 1. Indicate below any tablets not taken.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **MEDICATION** | **DATE** | **TIME** | **REASON MEDICATION NOT GIVEN** | **SIGNATURE** |
|  |  |  |  |  |
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|  |  |  |  |  |
|  |  |  |  |  |

**CARER PLEASE COMPLETE THESE DETAILS BELOW WHEN YOU EITHER RECEIVE DELIVERY OF/OR COLLECT MEDICATIONS NOT IN AN MDS**

|  |  |  |
| --- | --- | --- |
| **DATE MEDICATION COLLECTED OR RECEIVED DELIVERY OF** | **(Carer print name and signature)** | **ADDITIONAL NOTES** |
|  |  |
|  |  |
|  |  |
|  |  |

NAME OF CLIENT: …………………………………………………………….

ADDRESS OF CLIENT: ……………………………………………………………………………………………………………………………..

Page 2 of 2 Medicines Administration Record not in an MDS January 2011