RCPCH

St Elsewhere Hospital NHS
NHS Trust

START Assessment Prescription Chart

Full Name and address Or Patient Identifiable sticker	Hospital Number Date of birth
Drug Allergies/Reactions:	Consultant

IMPORTANT INFORMATION ABOUT THIS PRESCRIPTION

Ensure the patient's details are included on page 2

Doctor

1. Use approved names, write in BLOCK LETTERS, metric doses, English instructions and do not use abbreviations. Print your name or use initials, not an illegible signature.
2. Any changes in drug therapy must be ordered by a new prescription, **do not** alter existing instructions.
3. Stop a drug by drawing a line through it and a similar line through the next panels, and date and sign the relevant box.
4. When any section has filled up start a **new prescription sheet** if further drugs are required in that section.
   When a sheet is started all current prescriptions must be entered, so that only one sheet is in use.
   File the sheet no longer in use in the patient's medical record.
5. Prescribe infusion therapy and any drugs to be added to the infusion fluid on the intravenous infusion therapy chart. Additional intravenous therapy charts should be affixed to the original one if necessary.

Nurse

1. Check the entries in every box to avoid omissions.
2. Initial administration of drug in appropriate box.
3. If a drug is not given, enter the appropriate symbol in the appropriate box in RED ink. Use code for non administration as detailed on page 3.

ONCE ONLY AND PREMEDICATION DRUGS

Date	Drug (approved name)	Dose	Time	Route	Signature	Given by	Time given

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START Assessment Prescription Chart

Surname		DRUG ALLERGIES/REACTIONS
Forename(s)		
Date of birth	Weight	
Hospital No		

REGULAR PRESCRIPTIONS

Date and month

			Dose times↓												
Drug (approved name)															
Dose	Route	Start date													
Signature		Date stopped													
Additional instructions	Pharmacy														
Drug (approved name)															
Dose	Route	Start date													
Signature		Date stopped													
Additional instructions	Pharmacy														
Drug (approved name)															
Dose	Route	Start date													
Signature		Date stopped													
Additional instructions	Pharmacy														
Drug (approved name)															
Dose	Route	Start date													
Signature		Date stopped													
Additional instructions	Pharmacy														

AS REQUIRED PRESCRIPTIONS

Date and month

			Dose times↓												
Drug (approved name)															
Dose	Route	Start date													
Signature		Date stopped													
Additional instructions	Pharmacy														
Drug (approved name)															
Dose	Route	Start date													
Signature		Date stopped													
Additional instructions	Pharmacy														

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St Elsewhere Hospital NHS Trust NHS

Surname		DRUG ALLERGIES/REACTIONS
Forename(s)		
Date of birth	Weight	
Hospital No		

START Intravenous Infusion Therapy Chart

Use this section for intravenous infusion therapy.

Date	Intravenous infusion Fluid	Volume	Rate (or Duration)	Additives	Doctor's Signature	Batch Number	Nurse's Signature

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Outpatient prescription

Full Name and address Or Patient Identifiable sticker	Age and Date of birth
	Weight
	ALLERGIES

PRINT NAME
Signature
Date