

Forename:  
Surname:  
DOB:  
Hospital No.:  
Consultant:

PATIENT LABEL OR ADDRESSOGRAPH

Allergies / Adverse Drug Reactions	
Medicine/Other	Nature of Reaction

Or No known allergies

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Fluid +/- Electrolyte Infusions**

Date	Fluid +/- Electrolyte and Dose	Volume	Route	Duration /Rate	Start Time	Prescriber Sig & Reg No	Prepared by / Given by	Checked by	Admin Rate	Time Started
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