Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Medicines Request and Administration Record for Public Health Nursing Services

This is not a prescription

Patients Name		**Name of Patients GP:**
		Patient Aware of Referral: (tick) **Yes** ☐ **No** ☐
Address	Attach Addressograph Label	**DOB:**
		Patient Contact Tel No.:

Drug Allergy: **Yes** ☐ **No** ☐ *(if yes note type of allergy here)*

Current Medication: **Yes** ☐ **No** ☐ *(if yes attach a current list to this request form)*

This form is not suitable for requesting sliding scale therapy/ drug cycles.

Prescriber Request No. 1 / Nurse Administration Record No 1

Prescriber Request No. 1		Date 00/00/00	Time 00:00hr	Signature	Print name	Reasons for non administration (use codes 1 – 6)
Name of Drug (BLOCK LETTERS)						
Indication		This section must be completed before commencing page 2 Administration Continuation sheet				
Dose (eg. 10mgs)						
Route (eg. IM)						
Time (eg. 14:00hrs)						
Frequency (eg. weekly)						
Start date						
Administer until (insert date)						
Additional information/ special instructions						
Prescriber's signature						
Prescriber's location/ hospital/ ward /phone no.						
Date						
Print Name						
Registration No.						

Each drug request is valid for a maximum period of 9 months only.
If a medication is to continue beyond this period the prescriber must complete a new request form.
A new form must be completed for each drug dose adjustment.

Prescriber Request No. 2 / Nurse Administration Record No 2

Prescriber Request No. 2		Date 00/00/00	Time 00:00hr	Signature	Print name	Reasons for non administration (use codes 1 – 6)
Name of Drug (BLOCK LETTERS)						
Indication		This section must be completed before commencing page 2 Administration Continuation sheet				
Dose (eg. 10mgs)						
Route (eg. IM)						
Time (eg. 14:00hrs)						
Frequency (eg. weekly)						
Start date						
Administer until (insert date)						
Additional Information						
Prescriber's signature						
Prescriber's location/ hospital/ ward						
Date						
Print Name						
Registration No.						

This form must be signed by the authorised prescriber. If any part of this request is unclear the medication should not be administered by the registered nurse/midwife and the prescriber must be contacted to rewrite the request.
[HSE 2020 Procedure: Completion of medicines request and administration record for public health nursing services]

Reasons for non administration of medication: **1.** Patient did not attend/not at home **2.** Patient refused **3.** Medication unavailable **4.** Withheld as per Doctors Instructions **5.** Awaiting clarification **6.** Other

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Health Service Executive

Medicines Request and Administration Record for Public Health Nursing Services

Continuation Administration Record

Patients Name		Allergies Noted:
Address	Attach Addressograph Label	Additional Nursing Instructions:
DOB		
Contact Tel. No		

Nurse Administration Record No 1 Insert drug name

Date 00/00/00	Time 00:00hr	Dose	Route	Signature	Print name	Reasons for non administration (use codes 1 – 6)
Check both sides of page for date and time of last drug administration before administering the next dose						

Nurse Administration Record No 2 Insert drug name

Date 00/00/00	Time 00:00hr	Dose	Route	Signature	Print name	Reasons for non administration (use codes 1 – 6)
Check both sides of page for date and time of last drug administration before administering the next dose						

Reasons for non administration of medication: **1.** Patient did not attend/not at home **2.** Patient refused **3.** Medication unavailable **4.** Withheld as per Doctors Instructions **5.** Awaiting clarification **6.** Other