NAME: _____ MRN: _____

THROMBOPROPHYLAXIS RISK ASSESSMENT

Complete for all adult patients

Step One - *Assess Thrombosis Risk Factors:* Tick all boxes that apply OR tick here if NO thrombosis risk factor ☐

- Age > 60yr ☐
- Significant reduced mobility for >3 days including cast immobilisation ☐
- Active cancer or cancer treatment or possible new diagnosis of cancer ☐
- Medical co morbidities (e.g. heart disease, metabolic, endocrine or respiratory pathologies, acute infectious diseases, inflammatory conditions) ☐
- Personal history or first-degree relative with a history of VTE ☐
- On hormone replacement therapy (HRT) or oestrogen-containing contraceptives ☐
- Varicose veins with phlebitis ☐
- Acute Orthopaedic admission ☐
- Acute surgical admission/ surgery ☐
- Pregnancy or < 6 weeks post-part um ☐

Step Two - *Assess Bleeding Risk Factors:* Tick all boxes that apply OR tick here if NO anticoagulation risk factor ☐

- Active bleeding from any source/major bleeding risk e.g. peptic ulcer, liver disease ☐
- Concurrent use of anticoagulants e.g. warfarin INR >2, dabigatran, rivaroxaban, apixaban etc ☐
- Acute stroke or history of intracranial haemorrhage ☐
- Thrombocytopenia (platelets less than 75 x 109/L) ☐
- Uncontrolled hypertension (230 systolic or >120 diastolic) ☐
- Inherited bleeding disorders (such as haemophilia and Von Willebrand's disease) ☐
- Admitted for neurosurgery, spinal surgery/spinal injury or eye surgery ☐
- If lumbar puncture, spinal/epidural anaesthesia or epidural catheter planned or in situ and anticoagulation is indicated, refer to local guidelines for timing of anticoagulation ☐

Step Three - *Risk Stratification:*

1 or more ticks in Thrombosis risk assessment, **PLUS** No ticks in Bleeding risk assessment	1 or more ticks in Thrombosis risk assessment, **PLUS** 1 or more ticks in Bleeding risk assessment	**No** ticks in Thrombosis risk assessment
High risk of VTE with low risk of bleeding	**High risk of VTE with significant risk of bleeding**	**Low risk of VTE**
• LMWH thromboprophylaxis recommended (prescribe on top of opposite page) • Non pharmacological thromboprophylaxis unless contraindicated (see thromboprophylaxis guidelines) • Early mobilisation	• Non pharmacological thromboprophylaxis unless contraindicated (see thromboprophylaxis guidelines) • Early mobilisation • Consider Haematology consultation	• Non pharmacological thromboprophylaxis unless contraindicated (see thromboprophylaxis guidelines) • Early mobilisation

If LMWH not recommended put lines through Tinzaparin prescription box

Admission Assessment Completed

NCHD Name: _____ MCRN: _____

Signature: _____ Date: _____

Step Four - *Reassessment within 24 hours, whenever clinical situation changes and at discharge*

1. Date	Reason if change in Risk Assessment Outcome	Sign
2. Date	Reason if change in Risk Assessment Outcome	Sign

NAME_____ **MRN**_____

In the event of non-administration of a medication, enter the relevant code and initials in the appropriate box.

1. Patient away from ward
2. Patient could not receive drug-fasting
3. Patient refused medication
4. Drug not available on ward
5. Drug withheld on doctor's orders
6. Self Administration
7. No IV access
8. Patient own medication in use

REGULAR PRESCRIPTIONS			**DATE**														
TINZAPARIN				For extremes of body weight or significant renal impairments see Thrombophylaxis Guidelines													
			0600														
Circle dose 3500 IU 4500 IU	**Frequency OD**	**Route S/C**	1000														
			1200														
Prescribed by		Date	1400														
			1800														
Pharmacist		Disc. by	2200														
		Date	2400														
Drug (Approved Name)			0200														
			0600														
Dose	Frequency	Route	1000														
			1200														
Prescribed by		Date	1400														
			1800														
Pharmacist		Disc. by	2200														
		Date	2400														
Drug (Approved Name)			0200														
			0600														
Dose	Frequency	Route	1000														
			1200														
Prescribed by		Date	1400														
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Pharmacist		Disc. by	2200														
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Dose	Frequency	Route	1000														
			1200														
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		Date	2400														
Drug (Approved Name)			0200														
			0600														
Dose	Frequency	Route	1000														
			1200														
Prescribed by		Date	1400														
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Pharmacist		Disc. by	2200														
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REGULAR PRESCRIPTIONS			**DATE**														
Drug (Approved Name)			0200														
			0600														
Dose	Frequency	Route	1000														
			1200														
Prescribed by		Date	1400														
			1800														
Pharmacist		Disc. by	2200														
		Date	2400														
Drug (Approved Name)			0200														
			0600														
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Prescribed by		Date	1400														
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		Date	2400														

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			1200														
Prescribed by		Date	1400														
			1800														
Pharmacist		Disc. by	2200														
		Date	2400														

AS REQUIRED (PRN) PRESCRIPTIONS

Drug				Date												
Dose	Frequency	Route	Pharm	Time												
Special Instructions				Dose/ Rate												
Prescribed by				Given by												
Start Date		Review Date		Checked by												
Drug				Date												
Dose	Frequency	Route	Pharm	Time												
Special Instructions				Dose/ Rate												
Prescribed by				Given by												
Start Date		Review Date		Checked by												
Drug				Date												
Dose	Frequency	Route	Pharm	Time												
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Prescribed by				Given by												
Start Date		Review Date		Checked by												
Drug				Date												
Dose	Frequency	Route	Pharm	Time												
Special Instructions				Dose/ Rate												
Prescribed by				Given by												
Start Date		Review Date		Checked by												
Drug				Date												
Dose	Frequency	Route	Pharm	Time												
Special Instructions				Dose/ Rate												
Prescribed by				Given by												
Start Date		Review Date		Checked by												
Drug				Date												
Dose	Frequency	Route	Pharm	Time												
Special Instructions				Dose/ Rate												
Prescribed by				Given by												
Start Date		Review Date		Checked by												

AS REQUIRED (PRN) PRESCRIPTIONS

Drug				Date												
Dose	Frequency	Route	Pharm	Time												
Special Instructions				Dose/ Rate												
Prescribed by				Given by												
Start Date		Review Date		Checked by												
Drug				Date												
Dose	Frequency	Route	Pharm	Time												
Special Instructions				Dose/ Rate												
Prescribed by				Given by												
Start Date		Review Date		Checked by												
Drug				Date												
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Special Instructions				Dose/ Rate												
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Start Date		Review Date		Checked by												
Drug				Date												
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Prescribed by				Given by												
Start Date		Review Date		Checked by												
Drug				Date												
Dose	Frequency	Route	Pharm	Time												
Special Instructions				Dose/ Rate												
Prescribed by				Given by												
Start Date		Review Date		Checked by												

INFUSION PRESCRIPTIONS

Patient Name: _____ **Hospital No.** _____

Date	Infusion fluid	Vol.	Additives and dose	Rate	Prescriber's Signature	Start Time	Prepared by	Checked by

INFUSION PRESCRIPTIONS

Patient Name: _____ **Hospital No.** _____

Date	Infusion fluid	Vol.	Additives and dose	Rate	Prescriber's Signature	Start Time	Prepared by	Checked by

VARIABLE DOSE PRESCRIPTIONS (Steroids, Anti-coagulant and Antibiotics e.g. Vancomycin, Gentamicin, Netilmicin)

Prescription			Special Instructions	Date	Result	Dose	Prescribed By	Time given	Given by
DRUG (APPROVED NAME)									
Route	Start Date	Stop Date							
Prescribers Signature									
Pharmacist									
DRUG (APPROVED NAME)									
Route	Start Date	Stop Date							
Prescribers Signature									
Pharmacist									

ORAL ANTI-COAGULANT			Date												
DRUG		INR													
		Dose													
		Time													
Signature	Target INR	Dr.'s													
		Initials Given by													

INITIALS AND NAMES OF PERSONS ADMINISTERING MEDICATION

Initials	Name (Print)	Initials	Name (print)	Initials	Name (Print)

PRESCRIPTION WRITING POLICY FOR THE CORK UNIVERSITY HOSPITAL
April 2001

1. **Individual in-patient prescription charts must have complete details, as a minimum patient's full name AND hospital number AND date of birth. Preferably an addressograph sticker should be attached. The completeness of the patient details is the responsibility of the prescriber.**

2. **Drugs have to be prescribed legibly and in CAPITAL PRINT, in indelible ink.**

3. **Prescriptions have to be signed by a registered medical practitioner. Signature should be followed by the prescriber's bleep number. The bleep number will help nurses, clinical pharmacists and senior medical staff to reinforce adherence to this policy.**

4. **Names of drugs must be in generic format. For a transition period, it is advised to add the brand name in brackets, e.g. AMLODIPINE (ISTIN). Exceptions from the generic prescription are**
   - **Combination drugs, e.g. FRUIMIL although the use of the name CO-AMILOFRUSE (40mgs/50mgs), is encouraged;**
   - **preparations using slow or modified release formulations, e.g. MST;**
   - **the following drugs because of reasons of bioequivalence: all lithium, theophylline and diltiazem products.**

5. **Abbreviations, e.g. NSA, GTN, ASA, are not permitted.**

6. **Corrections can only be made by re-writing the prescription; crossing out, tipp-ex, etc. are not permitted.**

7. **Discontinued drugs must be signed and dated by the prescriber.**

8. **All drugs prescribed on separate charts, e.g. Insulin must be included on the prescription chart, e.g. Insulin see diabetic Chart.**

9. **Doses should follow the normal convention as follows: g for grams, mg for milligrams, micrograms and nanograms written in full. Avoid decimal points where possible, e.g. 250 micrograms, not 0.25 mg; 500 mg not 0.5 g, 1200 mg not 1.2 g.**

10. **Drug sensitivities (allergies) should be entered in the allocated box.**

11. **The same guidelines apply for drug prescription on HIPE forms and yellow prescriptions. Yellow prescriptions have to be used for all out-of-hospital prescriptions and non-formulary prescriptions. Numbered yellow prescriptions pads are available to doctors through pharmacy.**

Drugs and Therapeutics Committee

Form No. 10

Cork University Hospital
Medication Record

ALLERGIES: (INDICATE NATURE OF REACTION, IF KNOWN)					Affix addressograph here NAME: ADDRESS: DATE OF BIRTH: HOSPITAL NUMBER:
ADMISSION DATE	CHART NO.	WEIGHT KG	HEIGHT M	B.S.A M^2	
ADDITIONAL INFORMATION					

FOR THE SAFETY OF THE PATIENT

DOCTOR:

(1) Use approved names, BLOCK LETTERS, metric dosage and avoid abbreviations
(2) Any changes in drug therapy must be ordered by a new prescription, do not alter existing instructions
(3) To delete a prescription, insert the date discontinued, draw a line through the whole order and initial it
(4) If a section is full, transcribe all active orders onto a new Medication Record and file the old one in the patient's notes.

NURSE:

(1) Check entries in every section to avoid omissions.
(2) Initial the appropriate box when administering a drug. Include your initial and name once on the initials section.
(3) In the event of non-administration of a drug, enter the relevant code and initials in the appropriate box (see over) and record rationale for non-administration in nursing/medical records.

ONCE ONLY MEDICATION (INCLUDING PRE-MEDICATION)

DATE	TIME	DRUG (APPROVED NAME)	DOSE	ROUTE	DOCTOR'S SIGNATURE	TIME GIVEN	GIVEN BY

OXYGEN THERAPY: BY MASK OR NASAL PRONGS	FLOW RATE L/min	OXYGEN CONC %	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE

REGULAR PRESCRIPTIONS
FOR MEDICINES TO BE ADMINISTERED DURING REGULAR MEDICATION ROUNDS

REGULAR PRESCRIPTIONS			DATE														
Drug (Approved Name)			0200														
			0600														
Dose	Frequency	Route	1000														
			1200														
Prescribed by		Date	1400														
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Pharmacist		Disc. by	2200														
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