

Paper medication administration record

Sehlaam Home Care
Form DT-2 · nurses and doctors only

Give a medicine only as written on the current, approved medication order for this patient.

Never from memory or from the packet alone. If you cannot see the order, or it is unclear, do not give it: record M or N and phone the lead nurse. Check allergies before every dose.

Date	Patient number (PAT...)	Patient initials	Your name and role

Allergies (from the order or run sheet; write "none known, reviewed" only if that is what the record says)

Outcome: G given · R refused · W withheld (clinical reason) · M missed · N not available. Anything other than G needs a reason and who you told.

Medicine (as on the order)	Dose	Route	Due	Given at	Outcome	Initials	Reason · who you told

Your signature	Entered in Sehlaam (medication record) by / date and time
Checked by lead nurse / date	Differences found and how resolved

Confidential once completed. The person who gave the medicine enters it in Sehlaam from this form, as a late entry with the time given. A second clinician checks the entries against this form before it is filed.