

Intensive Care Unit

Medication Administration Record

Patient Name

Medical Record No.

Date of Birth

Room / Bed

Consultant

Date

Gender

| Date & Time | Medication Name | Dose | Route | Frequency | Prescriber Initial | Time Given | Nurse Initial | Remarks |
|-------------|-----------------|------|-------|-----------|--------------------|------------|---------------|---------|
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Nurse Signature:

Consultant Signature: