Surgical Inpatient Medication Administration Sheet

Patient Information

Name:

Hospital No.:

Ward/Bed:

Date of Birth/Age:

Consultant:

Date of Admission:

Allergies:

Prescribed Medication

Drug Name	Route	Dosage	Frequency	Start Date	Stop Date	Doctor's Signature

Administration Record

Date & Time	Drug Name	Dose Given	Route	Administered By (Name/Initials)	Signature	Remarks

Additional Notes