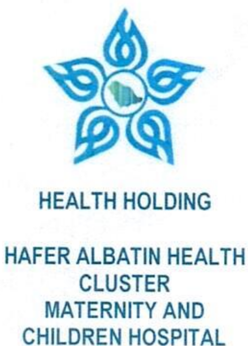

HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Provision of Care		
Document:	Multidisciplinary Policy and Procedure		
Title:	Transcription of Physician's Order		
Applies To:	All Nursing Staff		
Preparation Date:	January 05, 2025	Index No:	PC-MPP-016
Approval Date:	January 19, 2025	Version :	1
Effective Date:	February 19, 2025	Replacement No.:	PC-MPP-016 (N)
Review Date:	February 19, 2028	No. of Pages:	8

1. PURPOSE:

1.1 To outline the procedures for transcribing and verifying physician's orders.

2. DEFINITIONS:

2.1 Transcription of physician's orders: procedures for transcribing and verifying physician's orders by the nursing staff.

3. POLICY:

3.1 Nursing staff should perform proper and accurate transcription and verification.

4. PROCEDURE:

4.1 Transcription of orders:
- 4.1.1 The staff nurse always check the physician's order form and transcribe all medication orders on the medication form and other orders written for the patient.
- 4.1.2 Notify and clarify the physician for unclear orders.
- 4.1.3 Nurse in charge carries out the orders based on the following priority.
  - 4.1.3.1 STAT orders first- within 10 minutes.
  - 4.1.3.2 ASAP – within 30 minutes.
  - 4.1.3.3 Time – dependant orders - before time deadline
  - 4.1.3.4 Routine – wihin 1 hour.

4.2 Verification of orders:
- 4.2.1 Verify all transcribed orders:
  - 4.2.1.1 Right patient
  - 4.2.1.2 Right test/ exam/drug
  - 4.2.1.3 Right dose/ route/ frequency
  - 4.2.1.4 Right priority
  - 4.2.1.5 Right start date/ time
  - 4.2.1.6 Right stop date/ time
  - 4.2.1.7 Right performing dept./ location
- 4.2.2 For any unclear physician's order verify the physician who made the order.
- 4.2.3 If all orders have been transcribed and verified, the nurse should draw a straight line below the physician's name signature and stamp and write **Noted By** name of staff, ID number, date and time.

5. MATERIAL AND EQUIPMENT:

5.1 Unit Computers
5.2 Telephone

6. RESPONSIBILITIES:

6.1 Nurse

7. APPENDICES:

7.1 Physician's Order
7.2 Medication Sheet

8. REFERENCES:

8.1 MOH General Nursing Administration, Functions and Duties Policies and Procedures

9. APPROVALS:

	Name	Title	Signature	Date
Prepared by:	Ms. Rhodora Natividad	Document Management Control Coordinator		January 05, 2025
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Reviewed by:	Mr. Sabah Turayhib Al Harbi	Director of Nursing		January 07, 2025
Reviewed by:	Mr. Abdulellah Ayed Al Mutairi	QM&PS Director		January 08, 2025
Reviewed by:	Dr. Tamer Mohamed Naguib	Medical Director		January 12, 2025
Approved by:	Mr. Fahad Hazam AlShammari	Hospital Director		January 19, 2025

KINGDOM OF SAUDI ARABIA

وزارة الصحة
Ministry of Health

Hospital: ______________ مستشفى:

Region: ______________ المنطقة/المحافظة:

Dept./Unit: ______________ القسم/الوحدة:

MRN: | | | | | | | | | | رقم الملف الطبي:

Name: ______________ الاسم:

Nationality: ______________ الجنسية:

Age: ______ سنة Years ☐ شهر Months ☐ يوم Days ☐ العمر:

Date of Birth: ___/___/ 14___ H ___/___/ 20___ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

PHYSICIAN ORDER FORM

ALLERGIC TO:

DATE	TIME	PHYSICIAN ORDERS	PHYSICIAN STAMP / SIGNATURE	RN INITIAL / JOB NUMBER

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Ministry of Health

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Region: ______ المنطقة/المحافظة:

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Nationality: ______ الجنسية:

Age: ______ ☐ سنة Years ☐ شهر Months ☐ يوم Days العمر:

Date of Birth: ___/___/14___H ___/___/20___ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

MEDICATION ADMINISTRATION RECORD

Admission date:	Weight:	Height:

ALLERGIES: ☐ NKA ☐ Yes (If yes, include allergy to medications, food & blood products):

Nurse's Notes:

1. When a new prescription sheet is used, all current treatments must be fully re-written, re-signed.
2. Check for entries in every section in order to avoid omissions.
3. Follow medication administration and transcription order policy
4. In the event of a medicine not given, enter the appropriate code in the administration box available in page 2

ONCE ONLY PRESCRIPTION (STAT)

Date	Time Ordered	Drug	Dose	Route	Time given	Assigned Nurse Initial	Staff Nurse Initial

INTRAVENOUS SOLUTION

Date	Time Ordered	Types/ Volume of Fluids	Types/ Amount of Additives	Rate	Starting time	Assigned Nurse Initial	Staff Nurse Initial	Date/Time Discontinued

NOTE: Utilize the last page if the above spaces provided are insufficient.

NURSES IDENTIFICATION:

Name	Job Number	Initial	Name	Job Number	Initial	Name	Job Number	Initial

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Ministry of Health

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Region: ______________ المنطقة/المحافظة:

Dept./Unit: ______________ القسم/الوحدة:

MRN: | | | | | | | | | | رقم الملف الطبي:

Name: ______________ الاسم:

Nationality: ______________ الجنسية:

Age: ______ سنة Years ____ شهر Months ____ يوم Days العمر:

Date of Birth: ___ / ___ / 14___ H ___ / ___ / 20___ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

I.C.U MEDICATION ADMINISTRATION RECORD FORM

Admission date:	Weight:	Height:

Other cards in use (Please tick): Enteral nutrition TPN Anticoagulant

DRUG ALLERGIES:

DETAILS OF PREVIOUS MEDICATION:

Drug	Dose	Frequency	Duration of Treatment	Drug	Dose	Frequency	Duration of Treatment

ONCE ONLY PRESCRIPTION (STAT)

Date	Drug	Dose	Route	Time	Doctors Signature	Time given	Given by

NURSES IDENTIFICATION:

Initials	ID	Name	Initials	ID	Name	Initials	ID	Name

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Name: .... :الاسم	MRN: |_|_|_|_|_|_|_|_|_|_| :رقم الملف الطبي

NON- ADMINISTRATION
If a dose is not administered by a nurse for any reason, the nurse should initial the administration record and enter the appropriate code number.

CODES:
1. Allergic reaction
2. Patient fasting
3. Omitted for clinical reasons
4. Patient refused
5. Patient unavailability
6. Drug unavailability
7. Self administration

REGULAR MEDICATIONS			TIME DATE							
DRUG										
Route	Dose	Frequency								
Start date:		Other instructions:								
Doctor's Name:										
Doctor's Signature:										
DRUG										
Route	Dose	Frequency								
Start date:		Other instructions:								
Doctor's Name:										
Doctor's Signature:										
DRUG										
Route	Dose	Frequency								
Start date:		Other instructions:								
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Start date:		Other instructions:								
Doctor's Name:										
Doctor's Signature:										
DRUG										
Route	Dose	Frequency								
Start date:		Other instructions:								
Doctor's Name:										
Doctor's Signature:										

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Name:	الاسم:	MRN:	رقم الملف الطبي:

DRUG		
Route	Dose	Frequency
Start date:		Other instructions:
Doctor's Name:		
Doctor's Signature:		
DRUG		
Route	Dose	Frequency
Start date:		Other instructions:
Doctor's Name:		
Doctor's Signature:		
DRUG		
Route	Dose	Frequency
Start date:		Other instructions:
Doctor's Name:		
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Route	Dose	Frequency
Start date:		Other instructions:
Doctor's Name:		
Doctor's Signature:		

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Name:.. :الاسم	MRN: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] :رقم الملف الطبي

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Doctor's Name:										
Doctor's Signature:										

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