

Adult/Geriatric Medication Worksheet - Current Medications & PRN for Last 24 Hours

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
Click here to enter text.	Isotonic <input type="checkbox"/> Hypotonic <input type="checkbox"/> Hypertonic <input type="checkbox"/>	Click here to enter text.	Click here to enter text.	Click here to enter text.

Student Name: Akeeda Hunt		Unit: Click here to enter text.	Patient Initials: Click here to enter text.		Date: Click here to enter a date.	Allergies: Click here to enter text.	
Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Correct Dose? If not, what is correct dose?	IVP - List diluent solution, volume, and rate of administration IVPB - List concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
phenazopyridine	urinary tract analgesics, non opioid analgesics	Diminished urinary tract discomfort	PO (Adults): 200 mg 3 times daily for 2 days.	Choose an item. Click here to enter text.	Click here to enter text.	hepatotoxicity, nausea bright-orange urine, renal failure rash hemolytic anemia, methemoglobinemia headache, vertigo	<ol style="list-style-type: none"> 1. Assess patient for urgency, frequency, and pain on urination prior to and throughout therapy. 2. Instruct patient to take medication exactly as directed. If a dose is missed, take as soon as remembered unless almost time for next dose. 3. Instruct patient to notify health care professional if rash, skin discoloration, or unusual tiredness occurs. 4. Inform patient that drug causes reddish-orange discoloration of urine that may stain clothing or bedding. Sanitary napkin may be worn to avoid clothing stains. May also cause staining of soft contact lenses
amoxicillin	Aminopenicillins, antiulcer agents, anti-infectives	Bactericidal action; spectrum is broader than penicillins.	PO: 250-500 mg q 8 hr or 500-875mg q 12 hr (not to exceed	Choose an item. Click here to enter text.	Click here to enter text.	rash, urticaria CLOSTRIDIODES DIFFICILE-ASSOCIATED DIARRHEA (CDAD), diarrhea,	<ol style="list-style-type: none"> 1. Assess for infection (vital signs; appearance of wound, sputum, urine, and stool; WBC) at beginning of and throughout therapy 2. Monitor bowel function. Diarrhea, abdominal cramping, fever, and bloody stools should be reported to health care

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			<p>2-3 g/day). H. PyloriPO: Triple therapy- 1000 mg amoxicillin BID with lansoprazole 30 mg BID and clarithromycin 500 mg BID x14 days or 1000mg amoxicillin BID with omeprazole 20 mg BID + clarithromycin 500 mg BID x14 days or amoxicillin 1000 mg BID with esomeprazole 40 mg qd and clarithromycin 500 mg BID x10 days.</p>		<p>nausea vomiting, ↑ liver enzymes blood dyscrasias SEIZURES HYPERSENSITIVITY REACTIONS, SERUM SICKNESS, superinfection</p>	<p>professional promptly as a sign of Clostridioides difficile-associated diarrhea (CDAD). May begin up to several wk following cessation of therapy.</p> <p>3. Instruct patients to take medication around the clock and to finish the drug completely as directed, even if feeling better. Advise patients that sharing of this medication may be dangerous</p> <p>4. Advise patient to report the signs of superinfection (furry overgrowth on the tongue, vaginal itching or discharge, loose or foul-smelling stools) and allergy</p>
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			Dual therapy- 1000 mg amoxicillin TID + lansoprazole 30 mg three TID x 14 days.				
ceftriaxone	third generation cephalosporins, anti infectives	Bactericidal action against susceptible bacteria.	IM IV- Most infections 1-2 g q 12-24 hr Gonorrhea- 250 mg IM (single dose). Meningitis - 2 g q 12 hr. Perioperative prophylaxis- 1 g 0.5-2 hr before surgery x1	Choose an item. Click here to enter text.	Click here to enter text.	CLOSTRIDIODES DIFFICILE-ASSOCIATED DIARRHEA, diarrhea, cholelithiasis, rash, urticaria acute renal failure, urolithiasis bleeding, eosinophilia, hemolytic anemia, leukopenia, thrombocytosis pain at IM site, phlebitis at IV site SEIZURES ALLERGIC REACTIONS INCLUDING ANAPHYLAXIS, superinfection	<ol style="list-style-type: none"> 1. Observe patient for signs and symptoms of anaphylaxis (rash, pruritus, laryngeal edema, wheezing). Discontinue the drug and notify health care professional immediately if these symptoms occur. Keep epinephrine, an antihistamine, and resuscitation equipment close by in the event of an anaphylactic reaction. 2. Monitor bowel function. Diarrhea, abdominal cramping, fever, and bloody stools should be reported to health care professional promptly as a sign of Clostridioides difficile-associated colitis. May begin up to several wk following cessation of therapy. 3. Advise patient to report signs of superinfection (furry overgrowth on the tongue, vaginal itching or discharge, loose or foul-smelling stools) and allergy. 4. Instruct patient to notify health care professional if fever and diarrhea develop, especially if diarrhea contains blood, mucus, or pus. Advise patient not to treat diarrhea without consulting health care professional.
meropenem	carbapenems	Active against the following	Complicated	Choose an item.	Click here to enter text.	SEIZURES, dizziness,	<ol style="list-style-type: none"> 1. Monitor bowel function. Diarrhea, abdominal cramping, fever, and bloody

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		<p>gram-positive organisms:Staphylococcus aureus,Streptococcus agalactiae,Streptococcus pneumoniae,Streptococcus pyogenes,viridans group streptococci,Enterococcus faecalis.Also active against the following gram-negative pathogens:Escherichia coli,Haemophilus influenzae,Klebsiella pneumoniae,Neisseria meningitidis,Proteus mirabilis,Pseudomonas aeruginosa.Active against the following anaerobes:Bacteroides fragilis,Bacteroides thetaotaomicr</p>	<p>Skin/Skin Structure InfectionsI V: 500 mg q 8 hr or 1 g every 8 hr (if caused by Pseudomonas aeruginosa) ntra-abdominal InfectionsI V: 1 g every 8 hr</p>	<p>Click here to enter text.</p>		<p>headache DRUG REACTION WITH EOSINOPHILIA AND SYSTEMIC SYMPTOMS (DRESS), ERYTHEMA MULTIFORME, STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, CLOSTRIDIODES DIFFICILE-ASSOCIATED DIARRHEA APNEA HYPERSENSITIVITY REACTIONS</p>	<p>stools should be reported to health care professional promptly as a sign of Clostridioides difficile-associated diarrhea (CDAD). May begin up to several wk following cessation of therapy.</p> <p>2. Monitor for signs and symptoms of DRESS (fever, rash, lymphadenopathy, and/or facial swelling, associated with involvement of other organ systems (hepatitis, nephritis, hematologic abnormalities, myocarditis, myositis) during therapy. May resemble an acute viral infection. Eosinophilia is often present. Discontinue therapy if signs occur.</p> <p>3. Caution patient to notify health care professional if rash or fever and diarrhea occur, especially if stool contains blood, pus, or mucus. Advise patient not to treat diarrhea without consulting health care professional. May occur up to several wk after discontinuation of medication.</p> <p>4. Advise patient to report the signs of superinfection (black, furry overgrowth on the tongue; vaginal itching or discharge; loose or foul-smelling stools) and allergy.</p>
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		on,Peptostreptococcus spp.					
ciprofloxacin	fluoroquinolones	Death of susceptible bacteria.Spectrum:Active against gram-positive pathogens, including:Staphylococcus aureus,Staphylococcus epidermidis,Staphylococcus saprophyticus,Streptococcus pyogenes,Streptococcus pneumoniae,Enterococcus faecalis,Bacillus anthracis (anthrax).Gram-negative spectrum notable for activity against:E.coli,Klebsiella pneumoniae,Enterobacter cloacae,Salmonella typhi,Shigella spp,Proteus mirabilis,Prote	Skin/Skin Structure Infections PO: 500-750 mg q 12 hr for 7-14 days (ir) Bone and Joint Infections PO: 500-750 mg q 12 hr for 4-8 wk(i.r.) Complicated Intra-Abdominal Infections PO: 500 mg q 12 hr for 7-14 days Infectious DiarrheaPO: 500 mg q 12 hr for 5-7 days (i.r.) Typhoid FeverPO: 500 mg q 12 hr for 10 days	Choose an item. Click here to enter text.	IV: 400 mg every 8-12 hr for 7-14 days Bone and Joint Infections IV: 400 mg q 8-12 hr for 4-8 wk Complicated Intra-Abdominal Infections IV: 400 mg every 12 hr for 7-14 days. Inhalational Anthrax (Post-Exposure) IV: 400 mg every 12 hr for 60 days Plague IV: 400 mg every 8-12 hr for 14 days	AORTIC ANEURYSM/DISSECTION photosensitivity, rash hyperglycemia, hypoglycemia HEPATOTOXICITY, CLOSTRIDIODES DIFFICILE-ASSOCIATED DIARRHEA (CDAD), abdominal pain, diarrhea, nausea, ELEVATED INTRACRANIAL PRESSURE (INCLUDING PSEUDOTUMOR CEREBRI), SEIZURES, SUICIDAL THOUGHTS, agitation, confusion, HYPERSENSITIVITY REACTIONS (INCLUDING ANAPHYLAXIS)	1. Observe for signs and symptoms of anaphylaxis (rash, pruritus, laryngeal edema, wheezing). Discontinue drug and notify health care professional immediately if these problems occur. Keep epinephrine, an antihistamine, and resuscitation equipment close by in case of an anaphylactic reaction. 2. Monitor bowel function. Diarrhea, abdominal cramping, fever, and bloody stools should be reported to health care professional promptly as a sign of Clostridioides difficile-associated diarrhea (CDAD). May begin up to several wk following cessation of therapy. 3. Instruct patient to notify health care professional immediately if signs and symptoms of hepatotoxicity (anorexia, jaundice, dark urine, pruritus, or tender abdomen), rash, signs of hypersensitivity, serious CNS effects (seizures, increased intracranial pressure, and toxic psychosis including: nervousness, agitation, insomnia, anxiety, nightmares, paranoia, dizziness, confusion, tremors, hallucinations, depression, psychotic reactions, suicidal ideations/thoughts), peripheral neuropathy (pain, burning, tingling, numbness, and/or weakness, or other alterations in sensations including light touch, pain, temperature, position sense and vibratory sensation, and/or motor strength) or tendon (shoulder, hand, Achilles, and other) pain, swelling,

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		<p>us vulgaris, Providencia stuartii, Providencia rettgeri, Morganella morganii, Pseudomonas aeruginosa, Serratia marcescens, Haemophilus influenzae, Moraxella catarrhalis, Campylobacter jejuni, Yersinia pestis.</p>	<p>(i.r.) Uncomplicated Urethral and Cervical Gonorrhea PO: 250 mg single dose (i.r) Inhalational Anthrax (Post-Exposure) PO: 500 mg q 12 hr for 60 days (i.r.). Plague PO: 500-750 mg q 12 hr x 14 days (ir)</p>				<p>or inflammation occur. If tendon symptoms occur, avoid exercise and use of affected area. Increased risk in >65 yrs old, kidney, heart and lung transplant recipients, and patients taking corticosteroids concurrently. Therapy should be discontinued</p> <p>4. Instruct patient to notify health care professional if fever and diarrhea develop, especially if stool contains blood, pus, or mucus. Advise patient not to treat diarrhea without consulting health care professional.</p>
Niacin	water soluble vitamins, HMG-CoA Reductase inhibitors	Decreased blood lipids, Supplementations in deficiency states.	<p>PO: Hyperlipidemia- IR: 250 mg qd; ↑ dose q 4-7 days to desired response (usual dose = 1.5-2 g/day in 2-3</p>	<p>Choose an item.</p> <p>Click here to enter text.</p>	Click here to enter text.	<p>dizziness, nervousness, panic, orthostatic hypotension, HEPATOTOXICITY, GI upset, bloating, diarrhea, dry mouth, flushing of the face and neck, pruritus, burning, dry skin, glycosuria,</p>	<ol style="list-style-type: none"> 1. Obtain a diet history, especially with regard to fat consumption 2. Instruct patients taking long-term OTC extended-release niacin to report signs of hepatotoxicity (darkening of urine, light gray-colored stool, loss of appetite, severe stomach pain, yellow eyes or skin) to health care professional. 3. Advise patient to change positions slowly to minimize orthostatic hypotension. 4. Advise patient that this medication should be used in conjunction with dietary

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			divided doses); after 2-3 mo, may ↑ at 2-4 wk intervals to 1 g tid; ER: 500 mg q hs x 4 wk, then 1 g q hs x 4 wk; may then ↑ dose q 4 wk by 500 mg/day to maximum of 2 g/day. Dietary supplement- 50 mg bid or 100 mg qd.			hyperglycemia,	restrictions (fat, cholesterol, carbohydrates, alcohol), exercise, and cessation of smoking.
propranolol	beta blockers, antianginals antiarrhythmics (Class II) antihypertensives vascular headaches suppressants	Decreased heart rate and BP. Suppression of arrhythmias. Prevention of MI. Hemangioma resolution	PO: Antianginal- 80-320 mg/day in 2-4 divided doses or qd as extended/sustained-release	Choose an item. Click here to enter text.	IV: Antiarrhythmic- 1-3 mg; may be repeated after 2 min and again in 4 hr if needed.	fatigue, weakness, anxiety, dizziness, drowsiness, insomnia, ARRHYTHMIAS, BRADYCARDIA, HF, PULMONARY EDEMA, orthostatic	1. Monitor BP and pulse frequently during dose adjustment period and periodically during therapy. Abrupt withdrawal of propranolol may precipitate life-threatening arrhythmias, hypertension, or myocardial ischemia. Drug should be tapered over a 2-wk period before discontinuation. Assess patient carefully during tapering and after medication is discontinued. Consider that patients taking propranolol for non-cardiac indications may have undiagnosed cardiac

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			<p>capsules. Antihypertensive- 40 mg bid initially; may be ↑ as needed (usual range 120-240 mg/day; doses up to 1 g/day have been used); or 80 mg qd as extended/sustained-release capsules, ↑ as needed up to 120 mg. InnoPran XL dosing form is designed to be given qd qhs. Antiarrhythmic- 10-30 mg 3-4 times daily.</p>		<p>hypotension, ERYTHEMA MULTIFORME, EXFOLIATIVE DERMATITIS, STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, hyperglycemia, hypoglycemia, ANAPHYLAXIS, drug-induced lupus syndrome</p>	<p>disease. Abrupt discontinuation or withdrawal over too-short a period of time (less than 9 days) should be avoided.</p> <p>2. Patients receiving propranolol IV must have continuous ECG monitoring and may have pulmonary capillary wedge pressure (PCWP) or central venous pressure (CVP) monitoring during and for several hrs after administration.</p> <p>3. Monitor intake and output ratios and daily weight. Assess patient routinely for evidence of fluid overload (peripheral edema, dyspnea, rales/crackles, fatigue, weight gain, jugular venous distention)</p> <p>4. Assess for rash periodically during therapy. May cause Stevens-Johnson syndrome. Discontinue therapy if severe or if accompanied with fever, general malaise, fatigue, muscle or joint aches, blisters, oral lesions, conjunctivitis, hepatitis and/or eosinophilia</p>
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			<p>Prevention of MI- 180-240 mg/day in divided doses. Hypertrophic cardiomyopathy- 20-40 mg 3-4 times daily. Adjunct therapy of pheochromocytoma - 20 mg tid to 40 mg 3-4 times daily concurrently with alpha-blocking therapy, started 3 days before surgery is planned. Vascular headache prevention- 20 mg qid or 80</p>				
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			mg/day as extended/sustained-release capsules; may be ↑ as needed up to 240 mg/day. Management of tremor- 40 mg bid; may be ↑ up to 120 mg/day (up to 320 mg have been used).				
captopril	Antihypertensives ACE inhibitors	Lowering of BP in patients with hypertension. Improved survival and reduced symptoms in patients with heart failure. Improved survival and reduced development of overt heart failure after myocardial infarction. Decr	Hypertension PO: 12.5-25 mg 2-3 times daily, may be ↑ at 1-2 wk intervals up to 150 mg 3 times daily (initiate therapy with 6.25-12.5 mg	Choose an item. Click here to enter text.	Click here to enter text.	dizziness, fatigue, cough, hypotension, chest pain, palpitations, ANGIOEDEMA, AGRANULOCYTOSIS	<ol style="list-style-type: none"> 1. Assess patient for signs of angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing); may occur at any time during therapy. Discontinue medication and provide supportive care 2. Monitor CBC with differential prior to initiation of therapy, every 2 wk for the first 3 mo, and periodically for up to 1 yr in patients at risk for neutropenia (patients with renal impairment, or collagen-vascular disease) or at first sign of infection. Discontinue therapy if neutrophil count is <1000/mm³ 3. Caution patient to avoid salt substitutes containing potassium or foods containing

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		<p>eased progression of diabetic nephropathy with decreased need for transplantation or dialysis</p>	<p>2-3 times daily in patients receiving diuretics). Heart FailurePo: 25 mg tid (6.25-12.5 mg tid in patients who have been vigorously diuresed); titrated up to target dose of 50 mg tid(max dose = 450 mg/day). Left Ventricular Dysfunction Post-MI PO: 6.25-mg test dose, followed by 12.5 mg tid, may be ↑</p>				<p>high levels of potassium or sodium unless directed by health care professional. See food sources for specific nutrients</p> <p>4. Instruct patient to notify health care professional if immediately rash; mouth sores; sore throat; fever; swelling of hands or feet; irregular heart beat; chest pain; dry cough; hoarseness; swelling of face, eyes, lips, or tongue; difficulty swallowing or breathing occurs; or if taste impairment or skin rash persists. Persistent dry cough may occur and may not subside until medication is discontinued. Consult health care professional if cough becomes bothersome. Also notify health care professional if nausea, vomiting, or diarrhea occurs and continues</p>
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			up to 50 mg tid. Diabetic Nephropathy PO: 25 mg tid.				
losartan	Antihypertensives, angiotensin II receptor antagonists	Lowering of BP Decreased progression of diabetic nephropathy. Decreased incidence of stroke in patients with hypertension and left ventricular hypertrophy (effect may be less in black patients).	PO: Hypertension -50 mg qd initially (range 25-100 mg/day as a single daily dose or 2 divided doses) (initiate therapy at 25 mg qd in patients who are receiving diuretics or are volume depleted). Prevention of stroke in patients with hypertension and	Choose an item. Click here to enter text.	Click here to enter text.	dizziness, fatigue, headache, chest pain, edema, hypotension, nasal congestion, diarrhea, abdominal pain, hyperkalemia, ANGIOEDEMA,	<ol style="list-style-type: none"> 1. Assess patient for signs of angioedema (dyspnea, facial swelling). May rarely cause angioedema. 2. Emphasize the importance of continuing to take as directed, even if feeling well. Take missed doses as soon as remembered if not almost time for next dose; do not double doses. Medication controls but does not cure hypertension. Instruct patient to take medication at the same time each day. Warn patient not to discontinue therapy unless directed by health care professional. 3. Caution patient to avoid salt substitutes containing potassium or foods containing high levels of potassium or sodium unless directed by health care professional. See food sources for specific nutrients 4. Instruct patient to notify health care professional if swelling of face, eyes, lips, or tongue or if difficulty swallowing or breathing occur

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			<p>left ventricula r hypertrop hy- 50 mg qd initially; hydrochlo rothiazide 12.5 mg qd should be added and/or dose of losartan ↑ to 100 mg qd followed by an increase in hydrochlo rothiazide to 25 mg qd based on BP response; Nephropa thy in patients with type 2 diabetes -50 mg qd, may ↑ to 100 mg qd depending</p>			
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			on BP response Hepatic Impairment PO: Hypertension -25 mg qd initially; may be ↑ as tolerated				
Nitroglycerin	antianginals nitrates	Relief or prevention of anginal attacks. Increased cardiac output. Reduction of BP.	SL: Tablets- 0.3-0.6 mg; may repeat every 5 min for 2 additional doses for acute attack; may also be used prophylactically 5-10 min before activities that may precipitate an acute attack. Translingual Spray: 1-2	Choose an item. Click here to enter text.	IV: 5 mcg/min; ↑ by 5 mcg/min every 3-5 min to 20 mcg/min; if no response, ↑ by 10-20 mcg/min every 3-5 min (dosing determined by hemodynamic parameters; max: 200 mcg/min).	dizziness, headache, hypotension, tachycardia, syncope, flushing, alcohol intoxication (large IV doses only), tolerance	<ol style="list-style-type: none"> 1. Assess location, duration, intensity, and precipitating factors of patient's anginal pain. 2. Monitor BP and pulse before and after administration. Patients receiving IV nitroglycerin require continuous ECG and BP monitoring. Additional hemodynamic parameters may be monitored. 3. Advise patient to sit down and use medication at first sign of attack. Relief usually occurs within 5 min. Dose may be repeated if pain is not relieved in 5-10 min. Call health care professional or go to nearest emergency room if anginal pain is not relieved by 3 tablets in 15 min. 4. Inform patient that tablets should be kept in original glass container or in specially made metal containers, with cotton removed to prevent absorption. Tablets lose potency in containers made of plastic or cardboard or when mixed with other capsules or tablets. Exposure to air, heat, and moisture also causes loss of potency. Instruct patient not to open

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			<p>sprays; may be repeated every 5 min for 2 additional doses for acute attack; may also be used prophylactically 5-10 min before activities that may precipitate an acute attack. PO: 2.5-9 mg every 8-12 hr. Transdermal (Adults): Ointment - 1-2 in. every 6-8 hr. Transdermal patch- 0.2-0.4 mg/hr initially; may</p>			<p>bottle frequently, handle tablets, or keep bottle of tablets next to body (i.e., shirt pocket) or in automobile glove compartment. Advise patient that tablets should be replaced 6 mo after opening to maintain potency.</p>
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			titrate up to 0.4-0.8 mg/hr. Patch should be worn 12-14 hr/day and then taken off for 10-12 hr/day.				
furosemide	loop diuretics	Diuresis and subsequent mobilization of excess fluid (edema, pleural effusions).Decreased BP	PO: 20-80 mg/day as a single dose initially, may repeat in 6-8 hr; may ↑ dose by 20-40 mg every 6-8 hr until desired response. Maintenance doses may be given once or twice daily (doses up to 2.5 g/day have been	Choose an item. Click here to enter text.	IM IV (Adults): 20-40 mg, may repeat in 1-2 hr and ↑ by 20 mg every 1-2 hr until response is obtained, maintenance dose may be given every 6-12 hr; Continuous infusion- Bolus 0.1 mg/kg followed by 0.1 mg/kg/hr, double every 2 hr to a maximum of 0.4 mg/kg/hr.	Hypotension, ERYTHEMA MULTIFORME, STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, photosensitivity, hearing loss, tinnitus, hyperglycemia, dehydration, hypocalcemia, hypochloremia, hypokalemia, hypomagnesemia, hyponatremia, hypovolemia, metabolic alkalosis, APLASTIC ANEMIA, AGRANULOCYT	<ol style="list-style-type: none"> 1. Assess fluid status. Monitor daily weight, intake and output ratios, amount and location of edema, lung sounds, skin turgor, and mucous membranes. Notify health care professional if thirst, dry mouth, lethargy, weakness, hypotension, or oliguria occurs. 2. Monitor BP and pulse before and during administration. Monitor frequency of prescription refills to determine compliance in patients treated for hypertension. 3. Assess patient for skin rash frequently during therapy. Discontinue furosemide at first sign of rash; may be life-threatening. Stevens-Johnson syndrome, toxic epidermal necrolysis, or erythema multiforme may develop. Treat symptomatically; may recur once treatment is stopped 4. Advise patient to contact health care professional immediately if rash, muscle weakness, cramps, nausea, dizziness, numbness, or tingling of extremities occurs.

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			<p>used in patients with HF or renal disease). Hypertension- 40 mg bid initially (when added to regimen, ↓ dose of other antihypertensives by 50%); adjust further dosing based on response; Hypercalcemia- 120 mg/day in 1-3 doses HypertensionPO (Adults): 40 mg twice daily initially (when added to regimen, ↓ dose of</p>		<p>OSIS, dizziness, headache, vertigo</p>	
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			other antihypertensives by 50%); adjust further dosing based on response.				
digoxin	Antiarrhythmics inotropics, digitalis glycosides	Increased cardiac output (positive inotropic effect) and slowing of the heart rate (negative chronotropic effect).	PO: Digitalizing dose- 0.75-1.5 mg given as 50% of the dose initially and one quarter of the initial dose in each of 2 subsequent doses at 6-12 hr intervals. Maintenance dose- 0.125-0.5 mg/day depending on patient's lean body weight, renal function,	Choose an item. Click here to enter text.	IV IM (Adults): Digitalizing dose- 0.5-1 mg given as 50% of the dose initially and one quarter of the initial dose in each of 2 subsequent doses at 6-12 hr intervals.	fatigue, headache, weakness, ARRHYTHMIAS, bradycardia, ECG changes, AV block, SA block, anorexia, nausea, vomiting, electrolyte imbalances with acute digoxin toxicity	<ol style="list-style-type: none"> 1. Monitor ECG during IV administration and 6 hr after each dose. Notify health care professional if bradycardia or new arrhythmias occur. 2. Monitor intake and output ratios and daily weights. Assess for peripheral edema, and auscultate lungs for rales/crackles throughout therapy. 3. Teach patient to take pulse and to contact health care professional before taking medication if pulse rate is <60 or >100. 4. Instruct patient to notify health care professional of all Rx or OTC medications, vitamins, or herbal products being taken and to consult health care professional before taking other Rx, OTC, or herbal products, especially St. John's wort. Advise patient to avoid taking antacids or antidiarrheals within 2 hr of digoxin.

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			and serum level. PO Geriatric Patients: Initial daily dose should not exceed 0.125 mg.				
nifedipine	Antianginals antihypertensives calcium channel blockers	Systemic vasodilation, resulting in decreased BP. Coronary vasodilation, resulting in decreased frequency and severity of attacks of angina	PO: Immediate-release- 10-30 mg tid (not to exceed 180 mg/day); Extended-release- 30-90 mg qd (not to exceed 90-120 mg/day).	Choose an item. Click here to enter text.	Click here to enter text.	ARRHYTHMIAS, HF, peripheral edema, bradycardia, STEVENS-JOHNSON SYNDROME, flushing, hyperglycemia, headache, abnormal dreams, anxiety, confusion, dizziness, cough, dyspnea, shortness of breath	<ol style="list-style-type: none"> 1. Monitor BP and pulse before therapy, during dose titration, and periodically during therapy. Monitor ECG periodically during prolonged therapy. Monitor intake and output ratios and daily weight. Assess for signs of HF (peripheral edema, rales/crackles, dyspnea, weight gain, jugular venous distention) 2. Assess for rash periodically during therapy. May cause Stevens-Johnson syndrome. Discontinue therapy if severe or if accompanied with fever, general malaise, fatigue, muscle or joint aches, blisters, oral lesions, conjunctivitis, hepatitis, and/or eosinophilia. 3. Advise patient to notify health care professional if rash, irregular heartbeat, dyspnea, swelling of hands and feet, pronounced dizziness, nausea, constipation, or hypotension occurs or if headache is severe or persistent 4. Caution patient to change positions slowly to minimize orthostatic hypotension.
warfarin	Anticoagulants coumarins	Prevention of thromboembolic events.	PO: 2-5 mg/day for 2-4	Choose an item.	Click here to enter text.	dermal necrosis, CALCIPHYLAXIS,	<ol style="list-style-type: none"> 1. Assess for signs of bleeding and hemorrhage (bleeding gums; nosebleed; unusual bruising; tarry, black stools;

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		<p>days; then adjust daily dose by results of INR. Initiate therapy with lower doses in geriatric or debilitated patients or in Genetic implication Asian patients or those with CYP2C9*2 and/or CYP2C9*3 alleles or VKORC1 AA genotype.</p>	<p>Click here to enter text.</p>		<p>BLEEDING</p>	<p>hematuria; fall in hematocrit or BP; guaiac-positive stools, urine, or nasogastric aspirate).</p> <p>2. Assess for evidence of additional or increased thrombosis. Symptoms depend on area of involvement</p> <p>3. Review foods high in vitamin K (see food sources for specific nutrients). Patient should have consistent limited intake of these foods, as vitamin K is the antidote for warfarin, and alternating intake of these foods will cause PT levels to fluctuate. Advise patient to avoid cranberry juice or products during therapy.</p> <p>4. Advise patient to report any symptoms of unusual bleeding or bruising (bleeding gums; nosebleed; black, tarry stools; hematuria; excessive menstrual flow) and pain, color, or temperature change to any area of your body to health care professional immediately. Genetic implication Patients with a deficiency in protein C and/or S mediated anticoagulant response may be at greater risk for tissue necrosis.</p>
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