Your Hospital's Logo Here

M.A.R. VERIFIED

BY:_____

BOLUS

MEDICATION ADMINISTRATION RECORDS

				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Tube feeding of _____ (Product) via _____ tube. Give _____ ml Bolus _____ (q x hrs, or x times / day). Total cal _____. Total vol _____ ml's.																																		
Check tube for correct placement + patency before administering medication, starting pump and tube flushes.																																		
Flush _____ tube with _____ ml of water _____ (q x hrs or q x / day).																																		
				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

RESPONSE	MEDS NOT GIVEN	INJECTION SITES:		SIGNATURE / TITLE	INIT'LS	SIGNATURE / TITLE	INIT'LS
A. Relief in 30 Min	P. Patient Asleep	I. Right Deltoid Area	VI. Left Abdomen				
B. Relief in 60 Min	Q. Off of Unit	II. Left Deltoid Area	VII. Right Thigh				
C. No Relief	R. Refused	III. Right Gluteal Area	VIII. Left Thigh				
	S. NPO / Studies	IV. Left Gluteal Area	IX. Right Ventrogluteal				
	T. NPO / Surgery	V. Right Abdomen	X. Left Ventrogluteal				

DOCUMENTATION FOR PRN MEDICATIONS / MEDICATIONS NOT ADMINISTERED

DATE	Milit TIME	DRUG / STRENGTH / ROUTE	REASON	EFFECTIVE	NURSE INITIAL	DATE	Milit TIME	DRUG / STRENGTH / ROUTE	REASON	EFFECTIVE	NURSE INITIAL

NURSE INITIAL	NURSE'S SIGNATURE / TITLE	NURSE INITIAL	NURSE'S SIGNATURE / TITLE	NURSE INITIAL	NURSE'S SIGNATURE / TITLE