



# **Pharmacy Information System (PhIS) and Clinic Pharmacy System (CPS)**

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## **Full Based User Manual Ward Pharmacy**

<b>Version</b>	<b>: 10<sup>th</sup> EDITION</b>
<b>Document ID</b>	<b>: FB_U. MANUAL_WARD PHARMACY</b>



PhIS & CPS Project  
User Manual – Ward Pharmacy



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Reference ID : FB\_U. MANUAL\_WARD PHARMACY-10<sup>th</sup> EDITION

Application reference: PhIS & CPS v2.1 & v2.2

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## 1.0 Introduction

### 1.1 Overview of PhIS

Pharmacy Information System or better known as PhIS, is a complete and comprehensive system that integrates pharmacy related services geared towards pharmacy excellence. PhIS implementation would transform most of current manual process to electronic system would benefit facility end user in the health care sector.

There are 12 modules to assist services delivery by the health care sector which comprises of:

1. Order Management
2. Inpatient Pharmacy
3. Outpatient Pharmacy
4. Medication Counselling
5. Ward Pharmacy
6. Pharmacy Inventory
7. Manufacturing of Cytotoxic Drug Reconstitution, Parenteral Nutrition, IV Admixture & Eye Drop, Radiopharmaceuticals and Extemporaneous
8. Adverse Drug Reaction & Drug Allergic (ADR & DAC)
9. Clinical Pharmacokinetics Services (TDM)
10. Drug Information & Consumer Education (DICE)
11. Medication Therapy Adherence Clinic (MTAC)
12. Data Mining (PhARM)

### 1.2 Purpose and Objectives

This user manual outlines the Ward Pharmacy sub-module and its key features and functionalities. The primary objective is to help guide user through the process of completing PhIS application process.

User will understand the following activities in details:

- Ward Pharmacy (CP2)







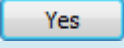
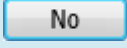
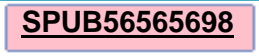
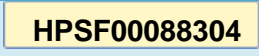

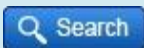




### 1.3 Organised Sections

These are the sections within this document:

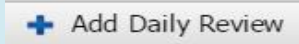

- Section 1: Introduction
- Section 2: Application Standard Features
- Section 3: Ward Pharmacy
- Section 4: Acronyms
- Section 5: Links to Clinical Modules

## 2.0 Application Standard Features

### 2.1 PhIS Legend

Standard Legend			
	Login to PhIS		Logout from PhIS
	Close All Open Tabs		Refresh Screen
	Expand Menu		Collapse Menu
	Expand Module		Collapse Module
	Add/Create New Record		Save
	Close Window		Calendar Icon
	Save Transaction		Delete Record
	Export Report From PDF file to Excel file		OK Button
	Yes Button		No Button
	Radio Button		Checkbox
	System Automatic Generate Record No.		Automatically Display/Retrieve Box
	Reset Login Screen		Show Help
	Display Home Tab		Search Record
	Cancel		Dropdown Box
	Search Icon		Mandatory Field
	Edit Record		Empty Text Box
	Cancel Button		

### Ward Pharmacy (CP2) Module Legend

	To record daily review patient		Add/update Record

### **Note**

To learn more about Login Information, kindly click [Login Information](#) module for descriptive steps.

## 2.2 Latest Enhancement and Updates

Latest Functions	Page
No more compliance score (Morisky scale) and change to Adherence score	<a href="#">9 &amp; 10</a>
CP2 HPI - To set maximum 500 characters	<a href="#">9 &amp; 10</a>
CP1 a) PMHx - To set maximum 500 characters b) Reason For Admission - To set maximum 500 characters c) Comments - To set maximum 500 characters d) Pharmacist Note - To set maximum 500 characters (Pharmacist Note has been remove in CP1 screen following the request of removing MMAS score. User can use Pharmacist note in CP2 screen)	<a href="#">14</a>

## 3.0 Ward Pharmacy

### Overview

The Ward Pharmacy module include Implementing safe and organized CP2 form, CP1 form, CP4 form, Pharmaceutical Care Issue (PCI) and lab result reporting

### User Group

This module is intended for pharmacist

### Functional Diagram

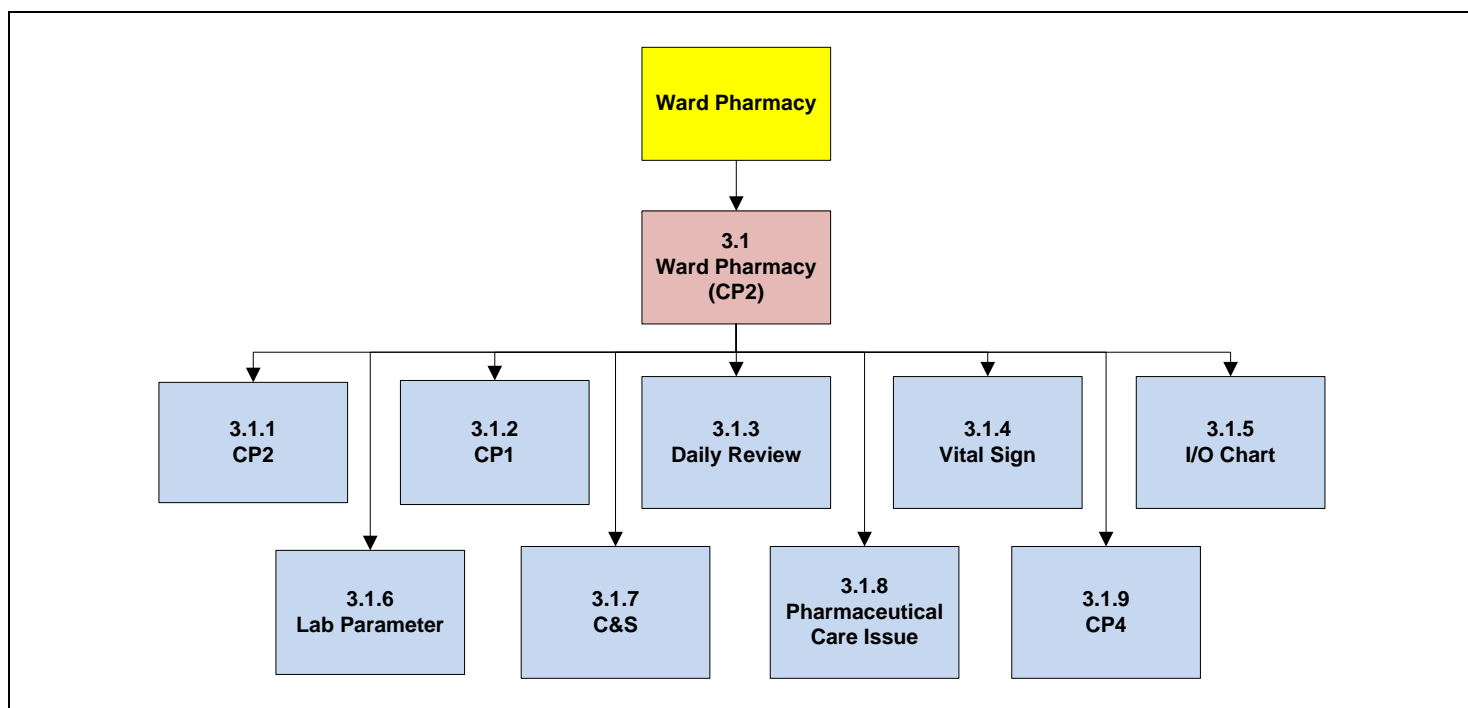


Figure 3.1

### Functional Description

Ward Pharmacy comprises of nine (9) functions:

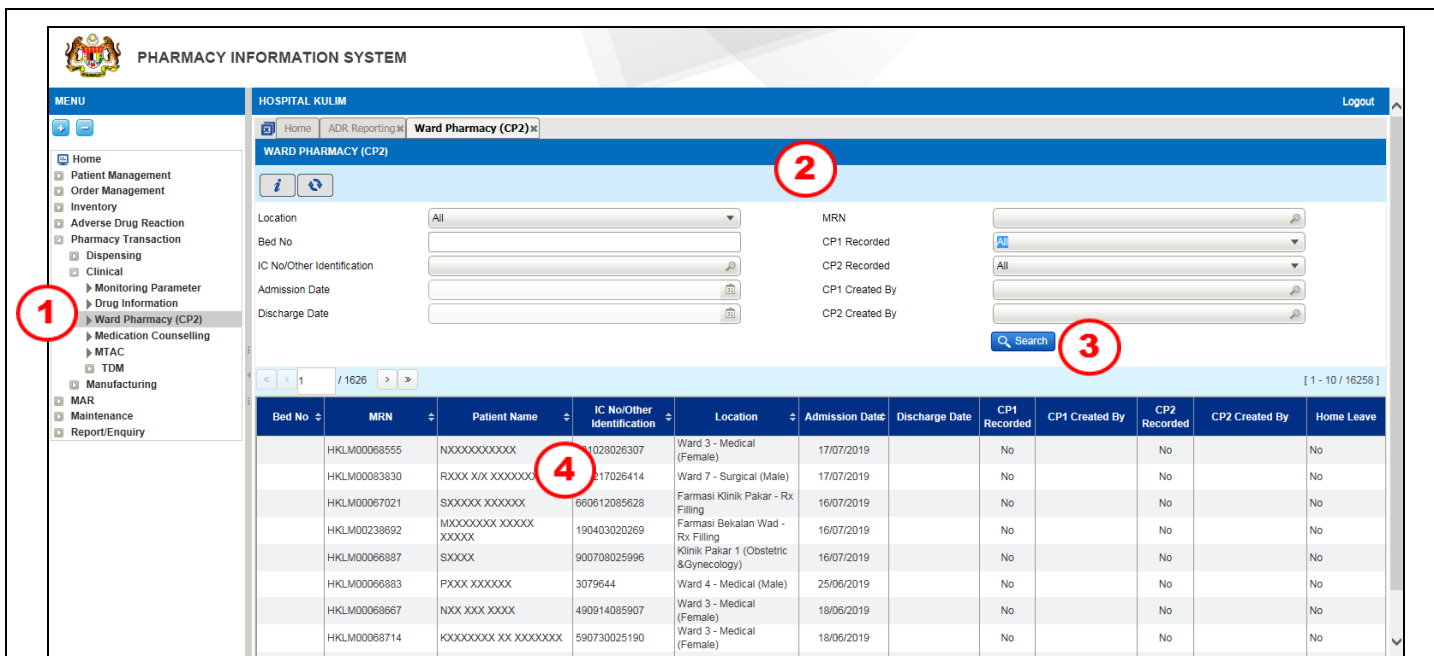
- CP1
- CP2
- Daily Review
- Vital Sign
- I/O Chart
- Lab Parameter
- C&S
- Pharmaceutical Care Issue
- CP4



## 3.1 Ward Pharmacy (CP2)

### 3.1.1 CP2

This function is used to transcribe CP2 form record in the system.



**PHARMACY INFORMATION SYSTEM**

**HOSPITAL KULIM** Logout

Home ADR Reporting Ward Pharmacy (CP2) x

**WARD PHARMACY (CP2)**

Location: All MRN: CP1 Recorded: CP2 Recorded: CP1 Created By: CP2 Created By: Search

1 / 1626 [ 1 - 10 / 16258 ]

Bed No	MRN	Patient Name	IC No/Other Identification	Location	Admission Date	Discharge Date	CP1 Recorded	CP1 Created By	CP2 Recorded	CP2 Created By	Home Leave
	HKLM00068555	NXXXXXXXXXX	1028026307	Ward 3 - Medical (Female)	17/07/2019		No		No		No
	HKLM00083830	RXXX XX XXXXXX	17026414	Ward 7 - Surgical (Male)	17/07/2019		No		No		No
	HKLM00067021	SXXXX XXXXXX	660612085628	Farmasi Klinik Pakar - Rx Filling	16/07/2019		No		No		No
	HKLM00238692	MXXXXXXXX XXXX XXXX	190403020269	Farmasi Bekalan Wad - Rx Filling	16/07/2019		No		No		No
	HKLM00066887	SXXXX	900708025996	Klinik Pakar 1 (Obstetric & Gynecology)	16/07/2019		No		No		No
	HKLM00066883	PXXX XXXXXX	3079644	Ward 4 - Medical (Male)	25/06/2019		No		No		No
	HKLM00068667	NXX XXX XXXX	490914085907	Ward 3 - Medical (Female)	18/06/2019		No		No		No
	HKLM00068714	KXXXXXXXX XX XXXXXX	590730025190	Ward 3 - Medical (Female)	18/06/2019		No		No		No

Figure 3.1.1-1 Ward Pharmacy Listing Page

#### Note

PhIs Screen menu/sub menu will be displayed according to user access right.

#### STEP 1

Click on Pharmacy Transaction menu then click on Clinical follow by click on Ward Pharmacy CP2

#### STEP 2


To search for patient Ward Pharmacy (CP2) records, user can search by criteria as follows:

Search			
No	Field	Description	Remark
a	Location	Location	Allow to search by assigned location: <ul style="list-style-type: none"> <li>- Inpatient visit</li> <li>- Emergency visit</li> <li>- Daycare visit</li> </ul>
b	MRN	Patient MRN	Allow to search by patient full or partial MRN No
c	Bed No	Bed No	Allow to search by patient bed no
d	IC No/Other Identification	IC No/Other Identification	Allow to search by patient full or partial IC No/Other Identification
e	CP1 Recorded?	<ul style="list-style-type: none"> <li>- All</li> <li>- Yes</li> <li>- No</li> </ul>	All-Allow to search by status 'Yes' and 'No' Yes-Allow to search by status 'Yes' No-Allow to search by status 'No'
f	CP2 Recorded?	<ul style="list-style-type: none"> <li>- All</li> </ul>	All-Allow to search by status 'Yes' and 'No'

		– Yes – No	Yes-Allow to search by status 'Yes' No-Allow to search by status 'No'
G	CP1 Created By	CP1 Created By	Allow to search CP1 created by
h	CP2 Created By	CP2 Created By	Allow to search CP2 created by
i	Admission Date	Date Enter Ward	Allow to search by date enter to ward
j	Discharged Date	Date Dismissed from Ward	Allow to search by date dismissed from ward

**Table 3.1.1-1**

### STEP 3

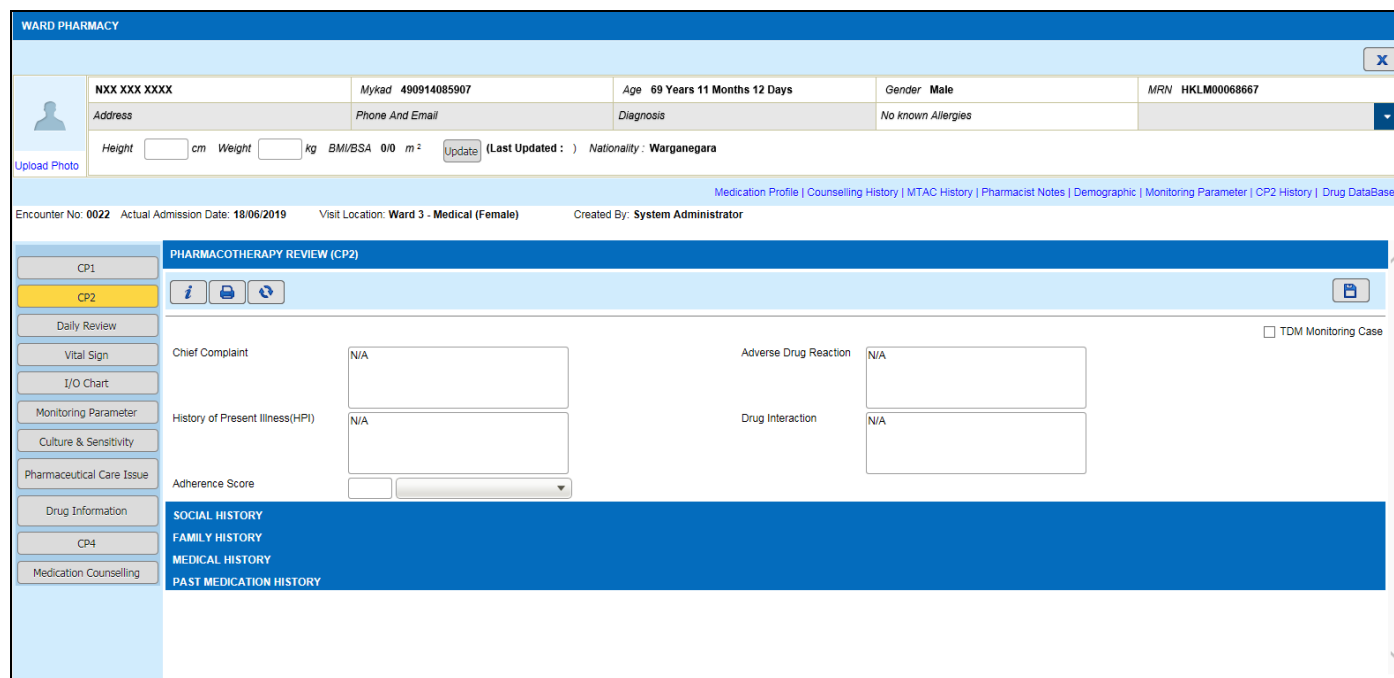
Click on the  button and result display will be based on the criteria

### Note

*If CP1 and CP2 already recorded for the particular patient, the listing will show Yes for both line.*

### STEP 4

Double click on patient name and user will enter the ward pharmacy CP2 function

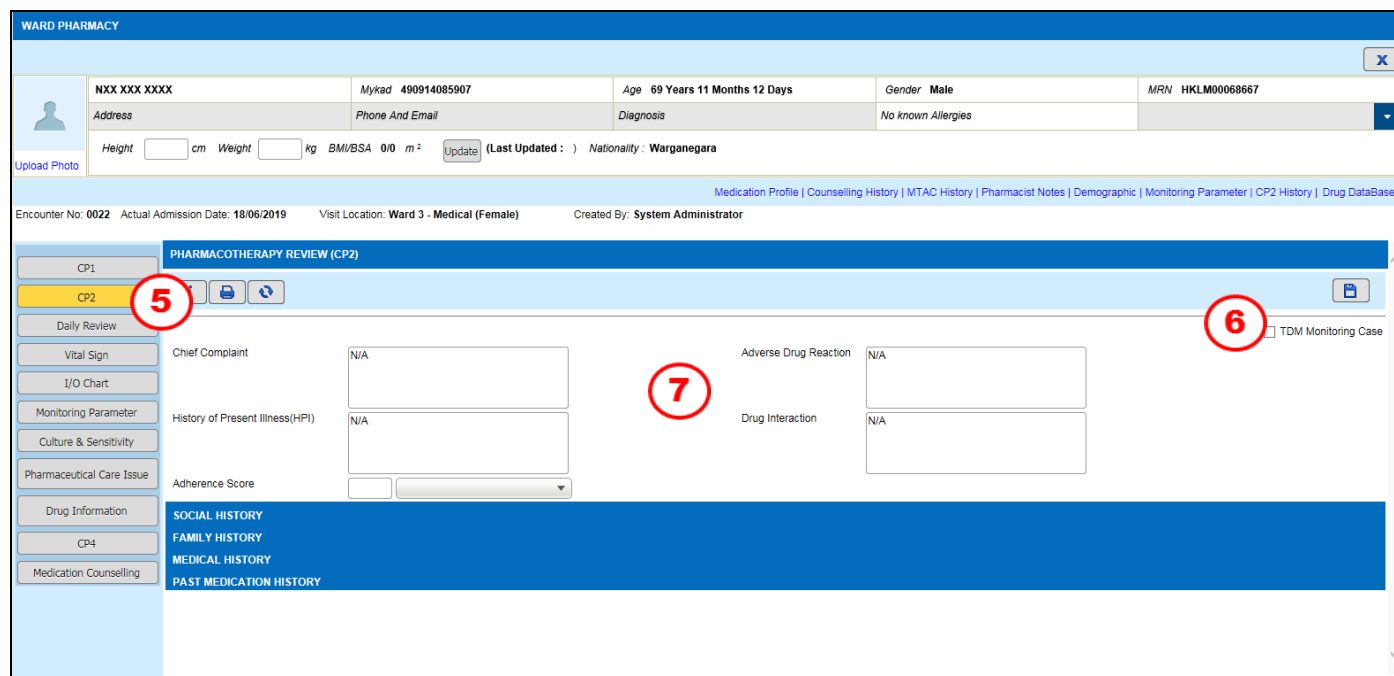


**Figure 3.1.1-2 Ward Pharmacy**

### Note

- By default system will CP2 screen
- User can navigate to other screen using tab on the left side that consist of:
  - CP1
  - CP2
  - Daily Review
  - Vital Sign
  - I/O Chart
  - Monitoring Parameter
  - Culture & Sensitivity

- *Pharmaceutical Care Issue*
- *Drug Information*
- *CP4*
- *Medication Counseling*



The screenshot displays the 'WARD PHARMACY' interface. At the top, there's a header bar. Below it, a patient information section includes fields for NXX XXX XXXX, Mykad 490914085907, Age 69 Years 11 Months 12 Days, Gender Male, and MRN HKLM00068667. There are also fields for Address, Phone And Email, Diagnosis, and No known Allergies. A section for Height, Weight, BMI/BSA, and an Update button is present. Below this, a navigation bar shows 'Encounter No: 0022', 'Actual Admission Date: 10/06/2019', 'Visit Location: Ward 3 - Medical (Female)', and 'Created By: System Administrator'. The main area features a 'PHARMACOTHERAPY REVIEW (CP2)' tab, which is highlighted with a red circle '5'. To the right of this tab, there's a checkbox for 'TDM Monitoring Case' with a red circle '6' next to it. The main content area is divided into several sections: 'Chief Complaint' (N/A), 'History of Present Illness (HPI)' (N/A), 'Adverse Drug Reaction' (N/A), 'Drug Interaction' (N/A), and 'Adherence Score'. A red circle '7' is placed over the 'History of Present Illness (HPI)' field. Below these sections, there's a blue bar with tabs for 'SOCIAL HISTORY', 'FAMILY HISTORY', 'MEDICAL HISTORY', and 'PAST MEDICATION HISTORY'. On the left side of the interface, there's a vertical menu with tabs for 'CP1', 'CP2' (highlighted), 'Daily Review', 'Vital Sign', 'I/O Chart', 'Monitoring Parameter', 'Culture & Sensitivity', 'Pharmaceutical Care Issue', 'Drug Information', 'CP4', and 'Medication Counseling'.

**Figure 3.1.1-3 Ward Pharmacy**

## STEP 5

Click on the **CP2** tab on the left side

### Note

CP2 consist of:

- *Main*
- *Social History*
- *Family History*
- *Medical History*
- *Past Medication History*

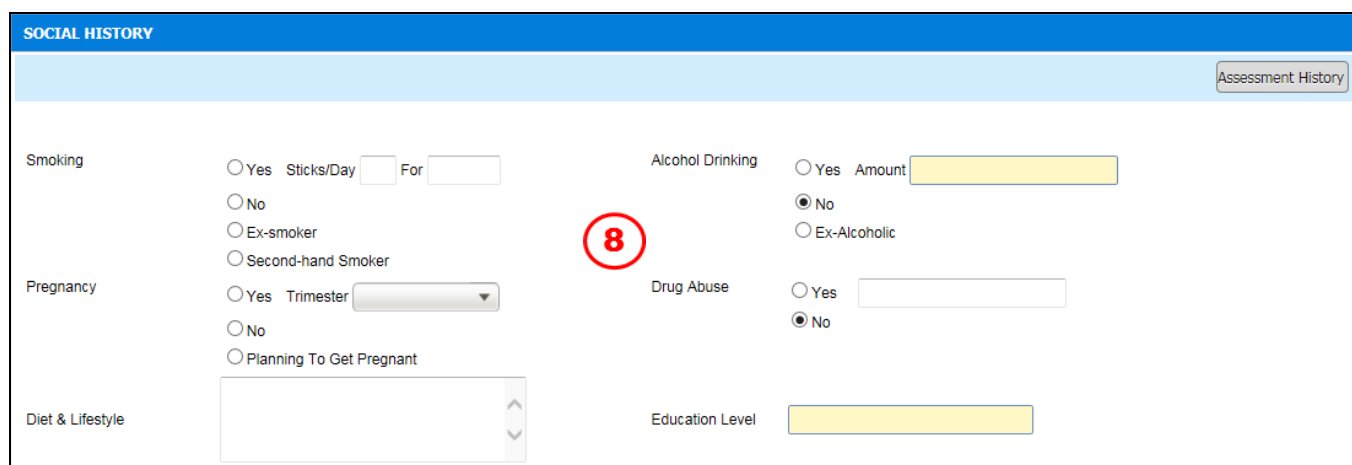
## STEP 6

Select on **TDM Monitoring Case** checkbox if applicable

## STEP 7

Enter the necessary information

- Chief Complaint**
- HPI**
- ADR**
- Drug Information**
- Adherence Score**



**SOCIAL HISTORY**

Assessment History

Smoking: ☐ Yes Sticks/Day  For  ☐ No ☐ Ex-smoker ☐ Second-hand Smoker

Pregnancy: ☐ Yes Trimester  ☐ No ☐ Planning To Get Pregnant

Diet & Lifestyle:

Alcohol Drinking: ☐ Yes Amount  ☒ No ☐ Ex-Alcoholic

Drug Abuse: ☐ Yes  ☒ No

Education Level:

Figure 3.1.1-4 Social History

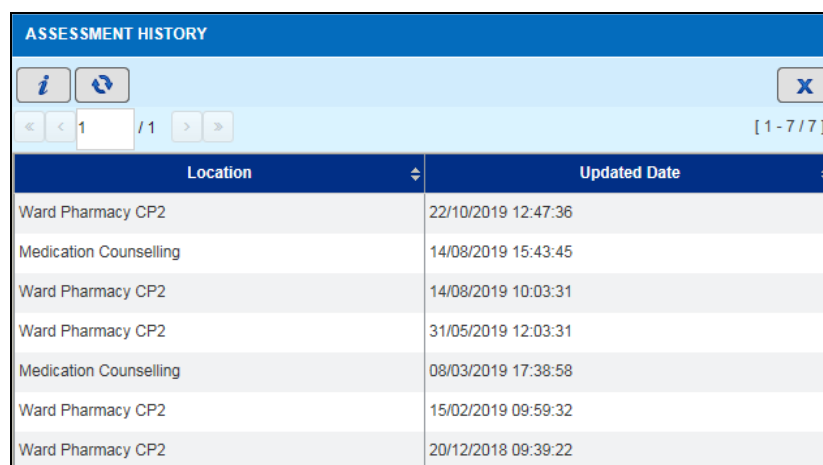
## STEP 8

Enter the necessary information in Social History section. Social History section consist of:

- Smoking**
- Pregnancy**
- Diet & Lifestyle**
- Alcohol Drinking**
- Drug Abuse**

## Note

- Pregnancy** field is disable if the patient gender is male
- Education** is retrieved from **Patient Registration** function
- Click on the **Assessment History** button to view Assessment History as shown in Figure 3.1.1-5



ASSESSMENT HISTORY	
Location	Updated Date
Ward Pharmacy CP2	22/10/2019 12:47:36
Medication Counselling	14/08/2019 15:43:45
Ward Pharmacy CP2	14/08/2019 10:03:31
Ward Pharmacy CP2	31/05/2019 12:03:31
Medication Counselling	08/03/2019 17:38:58
Ward Pharmacy CP2	15/02/2019 09:59:32
Ward Pharmacy CP2	20/12/2018 09:39:22

Figure 3.1.1-5 Assessment History

- User is allowed to copy information of Assessment History by double click on the selected record and the information will be updated into the Social History

FAMILY HISTORY	
Marital Status	Family History Of Illness
No. Of Children	
Lives With	
- Select -	

Figure 3.1.1-6 Family History

## STEP 9

Fill in the necessary information in Family History section. Family History section consist of:

- Marital Status**
- No Of Children**
- Lives With**
- Family History Of Illness**

## Note

Information in Marital Status is available if information is filled during patient registration function.

MEDICAL HISTORY	
+ Add	
Comorbidity	History
No Records Found!	
Surgical History	
<input type="radio"/> Yes	
<input type="radio"/> No	
Diagnostic Test	

Figure 3.1.1-7 Medical History

## STEP 10

Fill in the necessary information in Family History section. Family History section consist of:

- Comorbidity**
- Surgical History**
- Diagnostic Test**

## Note

User can add patient comorbidity by click on the  button

PAST MEDICATION HISTORY			
Prescription Medication			
[ 1 - 2 / 2 ]			
Drug Name	Dosage	Frequency	Remarks
Betahistine Dihydrochloride 24mg Tablet	24 mg	BD (twice daily)	Inpatient / 14-07-2016 / EncounterNo:0762
Metformin 500 mg and Glibenclamide 2.5 mg Tablet	2 tablet	BD (twice daily)	Inpatient / 14-07-2016 / EncounterNo:0762
Non Prescription Medication			
[ 1 - 2 / 2 ]			
Non-Prescription Medication(Includes Herbal/Vitamin/Other Supplements)	Balance/Comments	Source Of Medication	Reason For Taking
No Records Found!			

Figure 3.1.1-8 Past Medication History

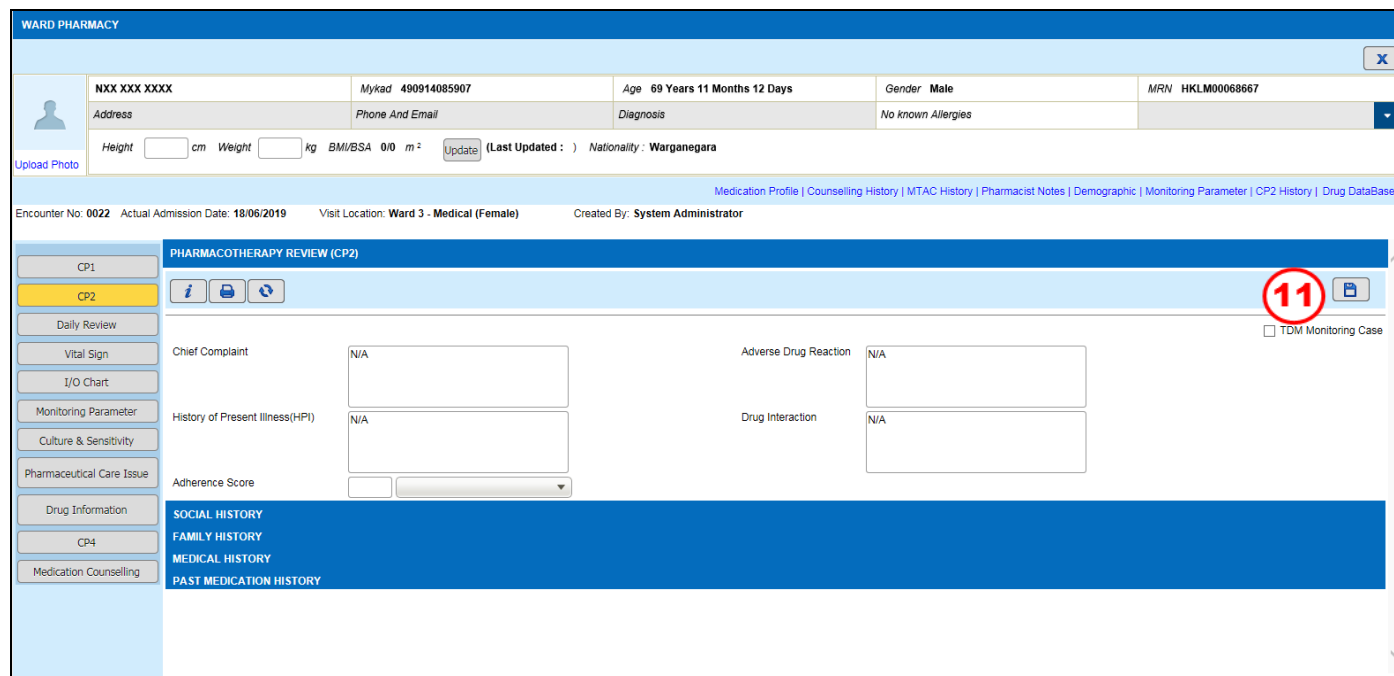
## Note

Past Medication History consist of:

- Prescription Medication


- *Non Prescription Medication*

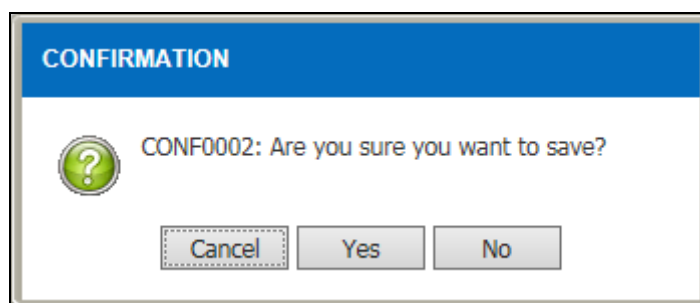
- *However, this field cannot be filling and need to be filled in CP1 screen.*



**Figure 3.1.1-9 Ward Pharmacy (CP2)**

## STEP 11

Click on the  button to save the CP2 record and system will display confirmation alert as figure 3.1.1-10



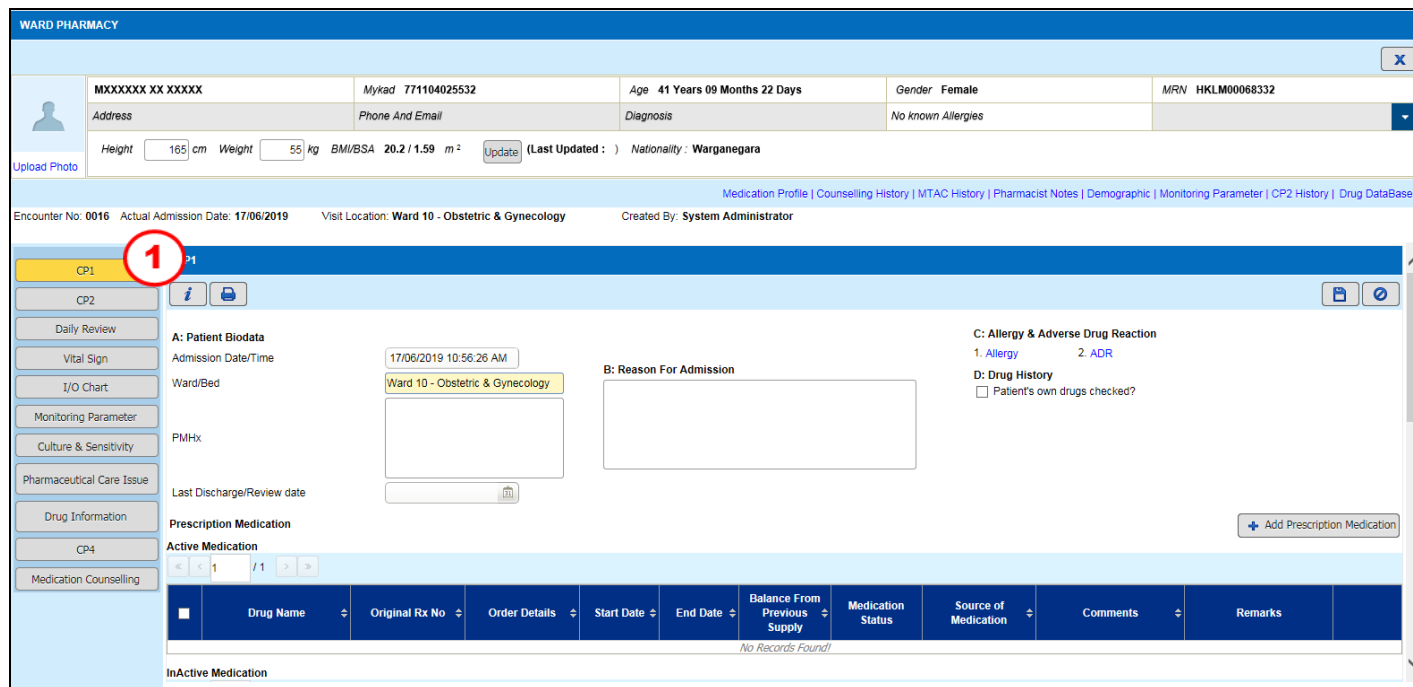
**Figure 3.1.1-10 Confirmation Alert**

## Note

- Click on Yes the button to save the record.

## 3.1.2 CP1

The function of this menu is to record a complete patient medication history within 24 hours of admission.

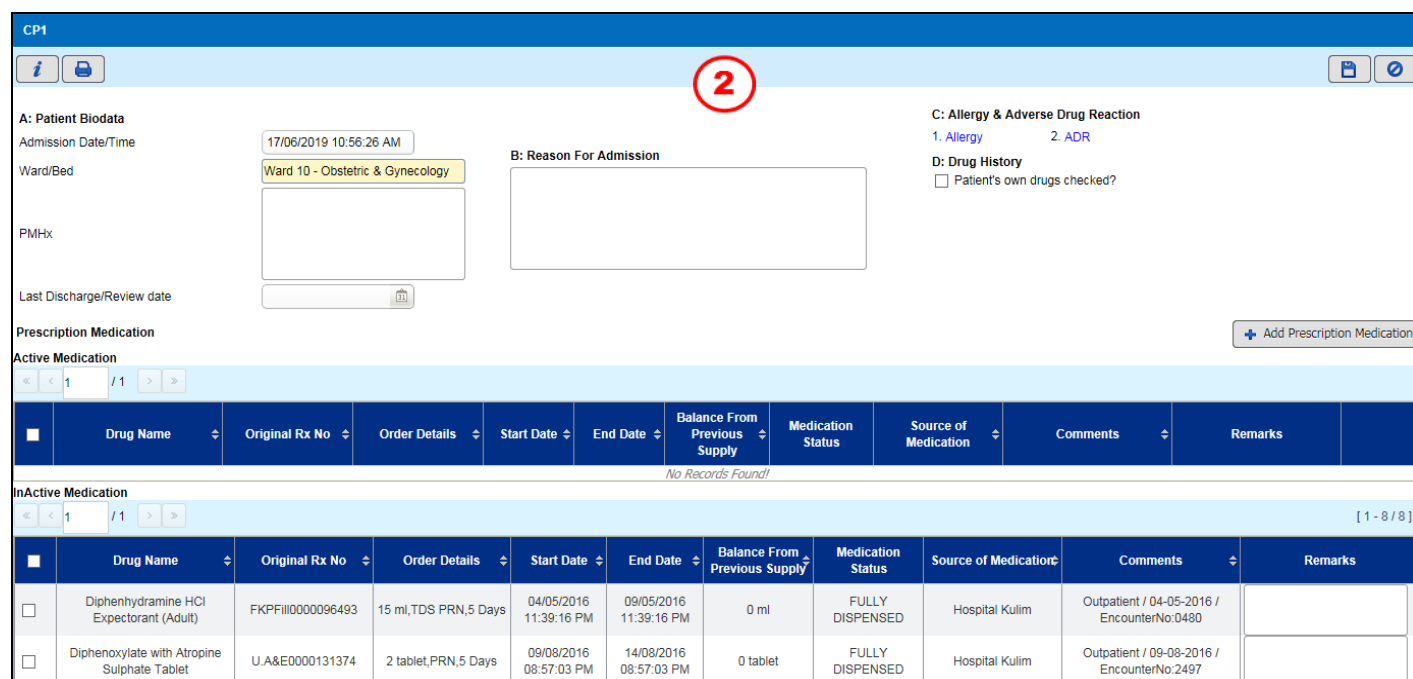


The screenshot shows the 'WARD PHARMACY' interface. At the top, there is a patient information header with fields for Mykad, Age, Gender, and MRN. Below this is a navigation bar with various tabs. The 'CP1' tab is highlighted with a red circle and the number '1'. The main content area displays patient biodata, admission date, ward/bed, and a table for active medication. The table has columns for Drug Name, Original Rx No, Order Details, Start Date, End Date, Balance From Previous Supply, Medication Status, Source of Medication, Comments, and Remarks. The table is currently empty, showing 'No Records Found!'.

Figure 3.1.2-1 CP1 Button

### STEP 1

Click on the **CP1** tab on the left side



The screenshot shows the 'WARD PHARMACY' interface with the 'CP1' tab selected. The main content area displays patient biodata, admission date, ward/bed, and a table for active medication. The table has columns for Drug Name, Original Rx No, Order Details, Start Date, End Date, Balance From Previous Supply, Medication Status, Source of Medication, Comments, and Remarks. The table is currently empty, showing 'No Records Found!'.

Figure 3.1.2-2 CP1

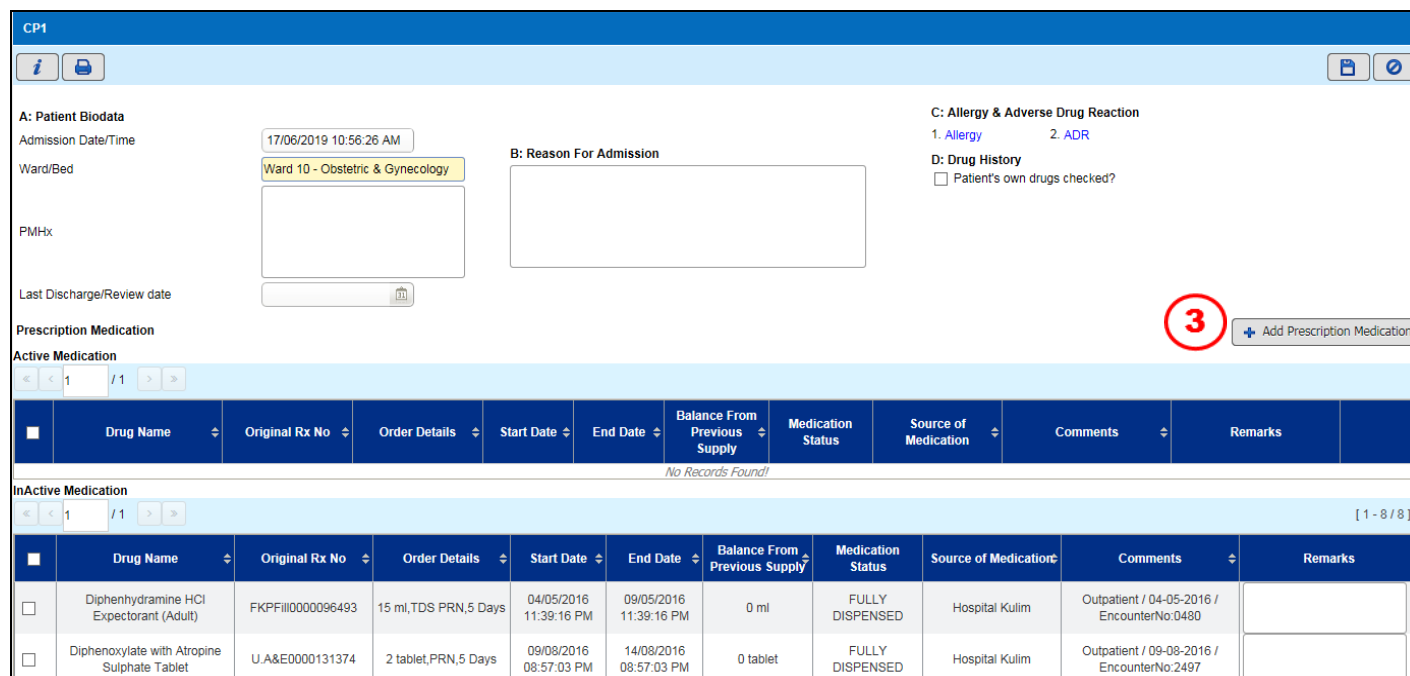
## STEP 2

Enter the necessary information

- A: Patient Biodata**
- B: Reason For Admission**
- D: Drug history**

### Note

User can view information of patient Allergy and ADR at **C: Allergy & Adverse Drug Reaction** hyperlink



CP1

A: Patient Biodata  
Admission Date/Time: 17/06/2019 10:56:26 AM  
Ward/Bed: Ward 10 - Obstetric & Gynecology  
PMHx:  
Last Discharge/Review date:

B: Reason For Admission

C: Allergy & Adverse Drug Reaction  
1. Allergy 2. ADR  
D: Drug History  
☐ Patient's own drugs checked?

Prescription Medication

Active Medication

Drug Name	Original Rx No	Order Details	Start Date	End Date	Balance From Previous Supply	Medication Status	Source of Medication	Comments	Remarks
No Records Found!									

InActive Medication

Drug Name	Original Rx No	Order Details	Start Date	End Date	Balance From Previous Supply	Medication Status	Source of Medication	Comments	Remarks
Diphenhydramine HCl Expectorant (Adult)	FKPFIII0000096493	15 ml, TDS, PRN, 5 Days	04/05/2016 11:39:16 PM	09/05/2016 11:39:16 PM	0 ml	FULLY DISPENSED	Hospital Kulim	Outpatient / 04-05-2016 / EncounterNo:0480	
Diphenoxylate with Atropine Sulphate Tablet	U.A&E0000131374	2 tablet, PRN, 5 Days	09/08/2016 08:57:03 PM	14/08/2016 08:57:03 PM	0 tablet	FULLY DISPENSED	Hospital Kulim	Outpatient / 09-08-2016 / EncounterNo:2497	

Figure 3.1.2-3 CP1

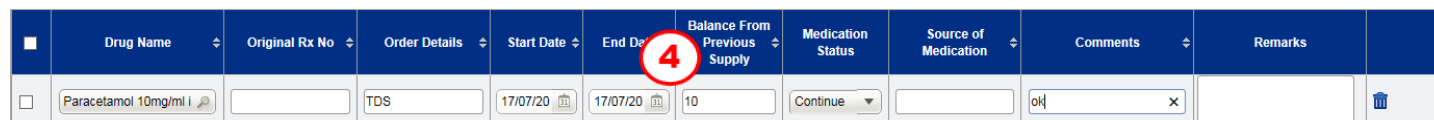
### Note

**Active Medication** : prescription with Current Medication and Partially Supply

**InActive Medication** : prescription with fully supply and it is past 1 year from order date including Stop drug except Cancel drug

## STEP 3

Click on the  button to enter the information as Figure 3.1.2-4.



Drug Name	Original Rx No	Order Details	Start Date	End Date	Balance From Previous Supply	Medication Status	Source of Medication	Comments	Remarks
Paracetamol 10mg/ml		TDS	17/07/20	17/07/20	10	Continue		ok	

Figure 3.1.2-4 Prescription Medication

## STEP 4


Fill in all the necessary information

- Drug Name**
- Original Rx No**
- Order Details**
- Start Date**
- End Date**



- f) **Balance From Previous Supply**
- g) **Medication Status**
- h) **Source of Medication**
- i) **Comments**
- j) **Remarks**

**Note**

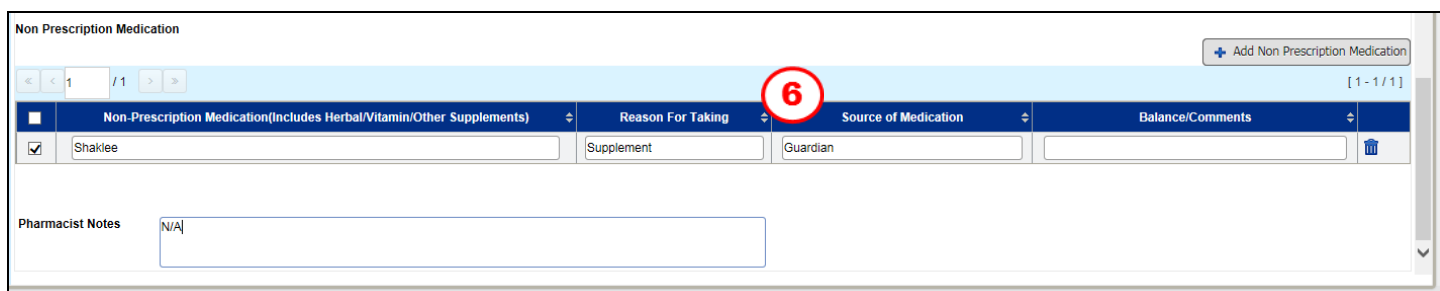
- User is allowed to enter multiple of Medication by following **STEP 3** to **STEP 4**
- User is allowed to delete the information by click on the  button



**Figure 3.1.2-6 CP1**

**STEP 5**

Click on the  button to enter the information as Figure 3.1.2-7



**Figure 3.1.2-7 Non Prescription Medication**

**STEP 6**

Fill in the necessary information

- a) **Non-prescription Medication (Includes Herbal/Vitamin/Other Supplemets)**
- b) **Source of Medication**
- c) **Reason for Taking**
- d) **Balance/Comments**

CP1
7

**A: Patient Biodata**

Admission Date/Time:

Ward/Bed:

PMHx:

Last Discharge/Review date:

**B: Reason For Admission**

**C: Allergy & Adverse Drug Reaction**

1. Allergy 2. ADR

**D: Drug History**

☐ Patient's own drugs checked?

+ Add Prescription Medication

**Prescription Medication**

**Active Medication**

< < 1 / 1 > >

Drug Name	Original Rx No	Order Details	Start Date	End Date	Balance From Previous Supply	Medication Status	Source of Medication	Comments	Remarks
<input type="checkbox"/> Benzydamine 3mg/ml throat spray						Continue			


**InActive Medication**

< < 1 / 1 > >
[ 1 - 8 / 8 ]


Drug Name	Original Rx No	Order Details	Start Date	End Date	Balance From Previous Supply	Medication Status	Source of Medication	Comments	Remarks
<input type="checkbox"/> Diphenhydramine HCl Expectorant (Adult)	FKPFI0000096493	15 ml,TDS PRN,5 Days	04/05/2016 11:39:16 PM	09/05/2016 11:39:16 PM	0 ml	FULLY DISPENSED	Hospital Kulim	Outpatient / 04-05-2016 / EncounterNo:0480	
<input type="checkbox"/> Diphenoxylate with Atropine Sulphate Tablet	U.A&E0000131374	2 tablet,PRN,5 Days	09/08/2016 08:57:03 PM	14/08/2016 08:57:03 PM	0 tablet	FULLY DISPENSED	Hospital Kulim	Outpatient / 09-08-2016 / EncounterNo:2497	

**Figure 3.1.2-9 CP1**

## STEP 7

Click on the  button to save the CP1 record and confirmation alert will display as Figure 3.1.2-10

CONFIRMATION


CONF0151: Are you sure you want to save?

Yes
No

**Figure 3.1.2-10 Confirmation Alert**

## Note

Information under Prescription Medication and Non Prescription will be display in the CP2 if user tick on the information checkbox.

## 3.1.3 Daily Review

To record Daily review, perform the step below:

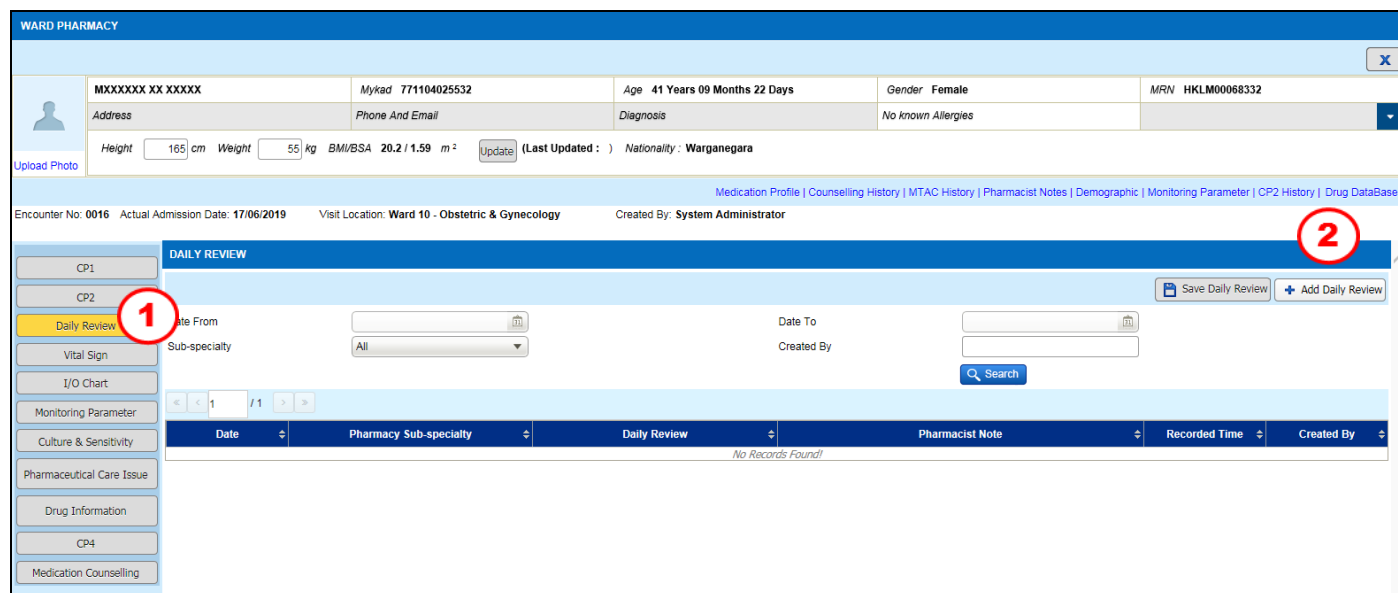


Figure 3.1.3-1 Daily Review

### STEP 1

Click on the **Daily Review** tab on the left side

### STEP 2

Click on the **+ Add Daily Review** button and Add Daily Review screen will be display as Figure 3.1.3-2

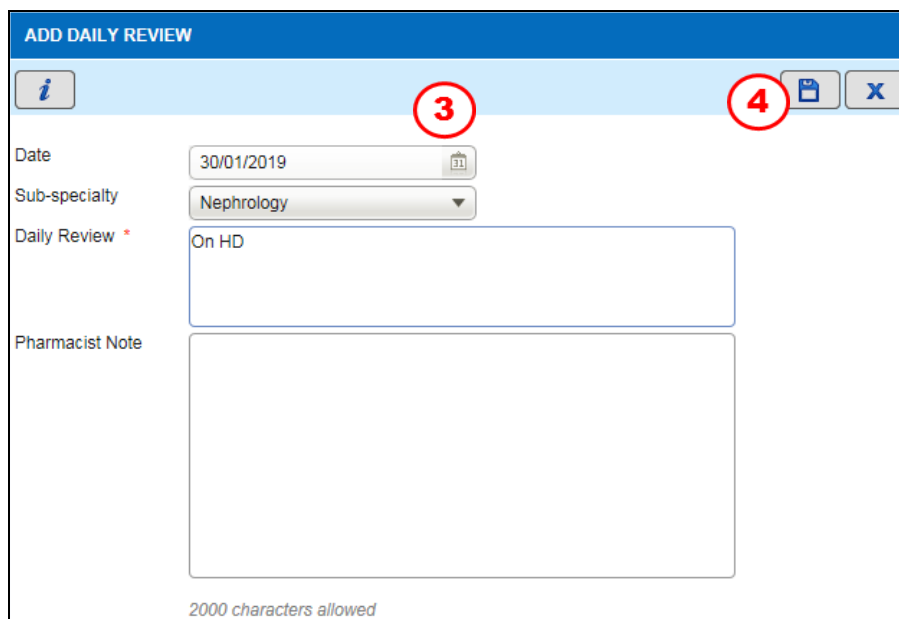



Figure 3.1.3-2 Add Daily Review

### STEP 3

Fill in necessary information

- Date**
- Sub-specialty**
- Daily Review (mandatory)**
- Pharmacist Note**

### STEP 4

Click on the  button to save the record and confirmation alert will displayed as Figure 3.1.3-3

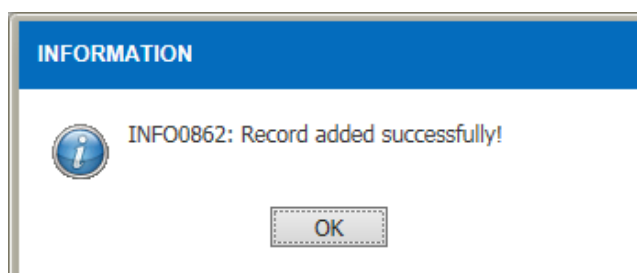
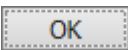
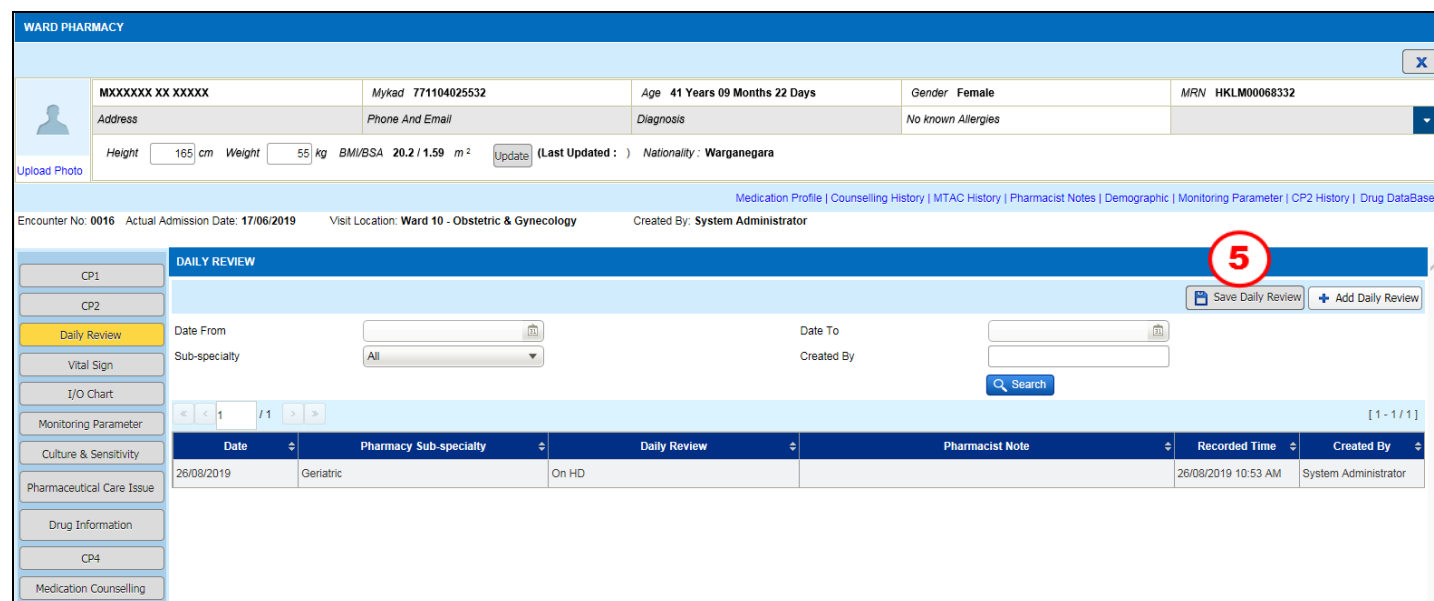


Figure 3.1.3-3 Confirmation Alert

### Note

- Click on the  button to successfully save the record
- After save the record, the information will displayed in the main screen as Figure 3.1.3-4



**WARD PHARMACY**

MXXXXXX XX XXXXX Mykad 771104025532 Age 41 Years 09 Months 22 Days Gender Female MRN HKLM00068332

Address Phone And Email Diagnosis No known Allergies

Height 165 cm Weight 55 kg BMI/BSA 20.2 / 1.59 m<sup>2</sup> Update (Last Updated : ) Nationality : Warganegara

Upload Photo

Medication Profile | Counseling History | MTAC History | Pharmacist Notes | Demographic | Monitoring Parameter | CP2 History | Drug DataBase |

Encounter No: 0016 Actual Admission Date: 17/06/2019 Visit Location: Ward 10 - Obstetric & Gynecology Created By: System Administrator

**DAILY REVIEW**

Save Daily Review Add Daily Review

Date From Date To Sub-specialty Created By Search

Date	Pharmacy Sub-specialty	Daily Review	Pharmacist Note	Recorded Time	Created By
26/08/2019	Geriatric	On HD		26/08/2019 10:53 AM	System Administrator

Figure 3.1.3-4 Daily Review

### Note

User is allowed to edit the record by double click on the information.

### STEP 5

Click on the  button to save the Daily review record

### 3.1.4 Vital Sign

To record Vital Sign, perform the step below:

WARD PHARMACY

XXXXXX XX XXXX

Mykad 771104025532

Age 41 Years 09 Months 22 Days

Gender Female

MRN HKLM00068332

Address

Phone And Email

Diagnosis

No known Allergies

Height 165 cm Weight 55 kg BMI/BSA 20.2 / 1.59 m<sup>2</sup>

Update (Last Updated : )

Nationality : Warganegara

Upload Photo

[Medication Profile](#) | [Counselling History](#) | [MTAC History](#) | [Pharmacist Notes](#) | [Demographic](#) | [Monitoring Parameter](#) | [CP2 History](#) | [Drug DataBase](#)

Encounter No: 0016 Actual Admission Date: 17/06/2019 Visit Location: Ward 10 - Obstetric & Gynecology Created By: System Administrator

CP1

CP2

Daily Review

Vital Sign

I/O Chart

Monitoring Parameter

Culture & Sensitivity

Pharmaceutical Care Issue

Drug Information

CP4

Medication Counselling

VITAL SIGN

Date/Time

Result

Normal Range

Vital Sign	Result	Adult	Children	Neonates	Infant
SBP (mmHg)		120	95 - 105	60 - 90	
DBP (mmHg)		80	53 - 66	20 - 60	
Temp (°C)		37	36.5 - 37	36.5 - 37	
PR (Pulse/min)		60 - 100	60 - 140	85 - 205	100 - 190
RR (Breaths/min)		12 - 18	18 - 30	30 - 60	30 - 40
Pain Score		0 - 10	0 - 10	0 - 10	0 - 10

Remarks

Figure 3.1.4-1 Vital Sign

#### STEP 1

Click on the **Vital Sign** tab on the left side

FB\_U. MANUAL\_WARD\_PHARMACY-10<sup>th</sup> E

Page 18

VITAL SIGN

Date/Time

26/08/2019 10:59 AM

Result	Normal Range																																										
<table> <thead> <tr> <th>Vital Sign</th> <th>Result</th> <th>Adult</th> <th>Children</th> <th>Neonates</th> <th>Infant</th> </tr> </thead> <tbody> <tr> <td>SBP (mmHg)</td> <td>118</td> <td>120</td> <td>95 - 105</td> <td>60 - 90</td> <td></td> </tr> <tr> <td>DBP (mmHg)</td> <td>79</td> <td>80</td> <td>53 - 66</td> <td>20 - 60</td> <td></td> </tr> <tr> <td>Temp (*C)</td> <td>37</td> <td>7</td> <td>36.5 - 37</td> <td>36.5 - 37</td> <td></td> </tr> <tr> <td>PR (Pulse/min)</td> <td>80</td> <td>60 - 100</td> <td>60 - 140</td> <td>85 - 205</td> <td>100 - 190</td> </tr> <tr> <td>RR (Breaths/min)</td> <td>14</td> <td>12 - 18</td> <td>18 - 30</td> <td>30 - 60</td> <td>30 - 40</td> </tr> <tr> <td>Pain Score</td> <td>9</td> <td>0 - 10</td> <td>0 - 10</td> <td>0 - 10</td> <td>0 - 10</td> </tr> </tbody> </table>	Vital Sign	Result	Adult	Children	Neonates	Infant	SBP (mmHg)	118	120	95 - 105	60 - 90		DBP (mmHg)	79	80	53 - 66	20 - 60		Temp (*C)	37	7	36.5 - 37	36.5 - 37		PR (Pulse/min)	80	60 - 100	60 - 140	85 - 205	100 - 190	RR (Breaths/min)	14	12 - 18	18 - 30	30 - 60	30 - 40	Pain Score	9	0 - 10	0 - 10	0 - 10	0 - 10	
Vital Sign	Result	Adult	Children	Neonates	Infant																																						
SBP (mmHg)	118	120	95 - 105	60 - 90																																							
DBP (mmHg)	79	80	53 - 66	20 - 60																																							
Temp (*C)	37	7	36.5 - 37	36.5 - 37																																							
PR (Pulse/min)	80	60 - 100	60 - 140	85 - 205	100 - 190																																						
RR (Breaths/min)	14	12 - 18	18 - 30	30 - 60	30 - 40																																						
Pain Score	9	0 - 10	0 - 10	0 - 10	0 - 10																																						

Remarks

Delete

Add/Update

Result List

<

<

1

/ 1

>

>

Date/Time	SBP	DBP	Temp	PR	RR	Pain Score	Remarks
No Records Found!							

Figure 3.1.4-2 Vital Sign

## STEP 2

Select **Sample Date/Time**

## STEP 3

Fill in necessary information

- SBP (mmHg)**
- DBP (mmHg)**
- Temp (\*C)**
- PR (Pulse/min)**
- RR (Breaths/min)**
- Pain Score**
- Remarks**

## STEP 4

Click on the **Add/Update** button to add the information in to Result List as shown in Figure 3.1.4-3

Result List							
<div> <div>&lt;</div> <div>&lt;</div> <div>1</div> <div>/ 1</div> <div>&gt;</div> <div>&gt;</div> </div> <div>[ 1 - 1 / 1 ]</div>							
Date/Time	SBP	DBP	Temp	PR	RR	Pain Score	Remarks
26/08/2019 10:59 AM	118	79	37	80	14	9	

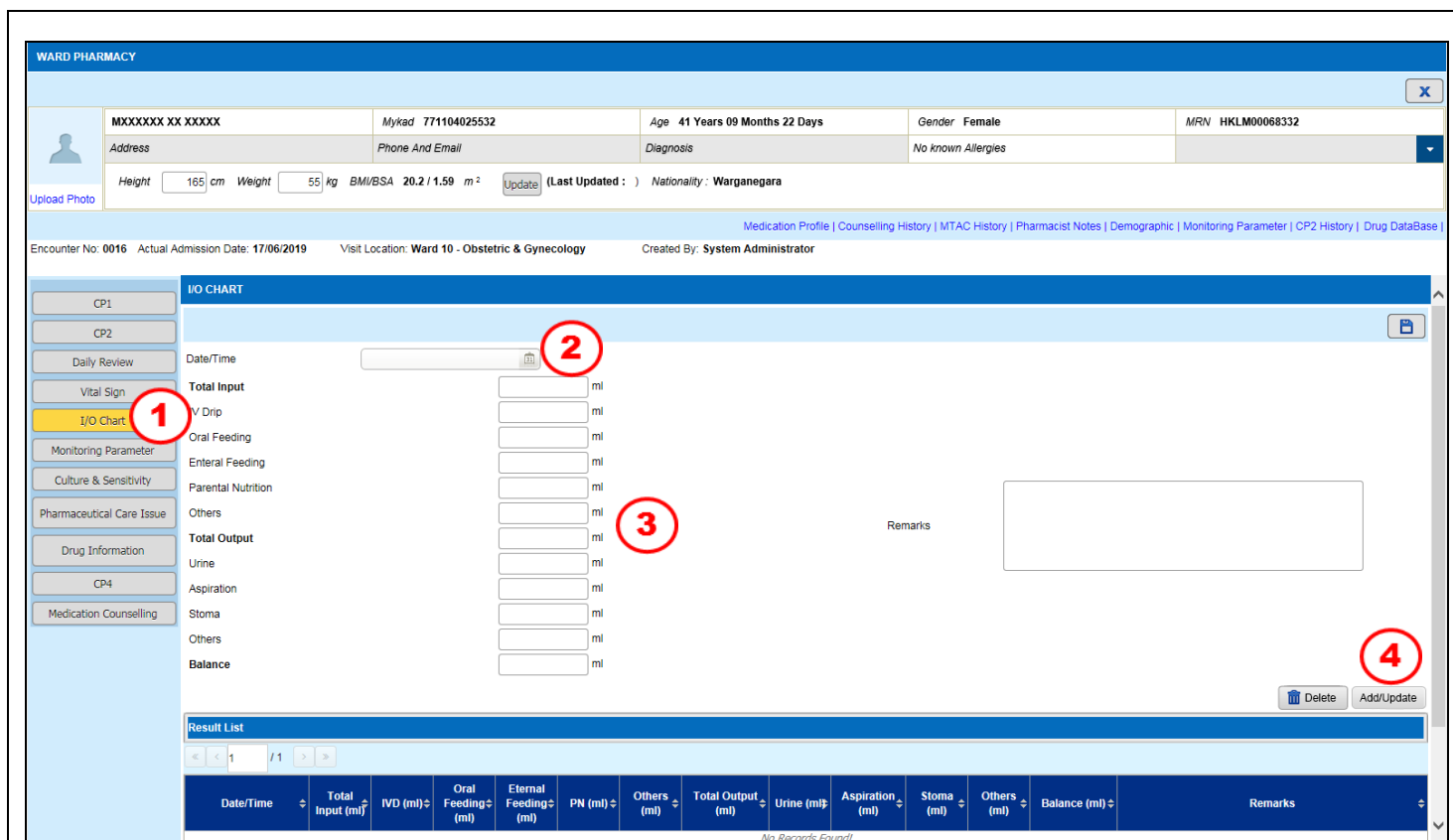
Figure 3.1.4-3 Vital Sign

## Note

- User is allowed to delete the record by click on the  button
- User is allowed to update the record by double click on the information in the Result List and edit the information if applicable

### 3.1.5 I/O Chart

To record I/O Chart, perform the step below:



**WARD PHARMACY**

MXXXXX XX XXXXX Mykad 771104025532 Age 41 Years 09 Months 22 Days Gender Female MRN HKLM00068332

Address Phone And Email Diagnosis No known Allergies

Height 165 cm Weight 55 kg BMI/BSA 20.2 / 1.59 m<sup>2</sup> Update (Last Updated : ) Nationality : Warganegara

Encounter No: 0016 Actual Admission Date: 17/06/2019 Visit Location: Ward 10 - Obstetric & Gynecology Created By: System Administrator

**I/O CHART**

CP1 CP2 Daily Review Vital Sign **I/O Chart** Monitoring Parameter Culture & Sensitivity Pharmaceutical Care Issue Drug Information CP4 Medication Counselling

Date/Time **2**

Total Input  ml

IV Drip  ml

Oral Feeding  ml

Enteral Feeding  ml

Parental Nutrition  ml

Others  ml **3**

Total Output  ml

Urine  ml

Aspiration  ml

Stoma  ml

Others  ml

Balance  ml

Remarks

**4** Delete Add/Update

**Result List**

Date/Time	Total Input (ml)	IVD (ml)	Oral Feeding (ml)	Enteral Feeding (ml)	PN (ml)	Others (ml)	Total Output (ml)	Urine (ml)	Aspiration (ml)	Stoma (ml)	Others (ml)	Balance (ml)	Remarks
No Records Found!													

Figure 3.1.5-1 I/O Chart

#### STEP 1

Click on the **I/O Chart** tab on the left side

#### STEP 2

Select **Sample Date/Time**

#### STEP 3

Fill in all necessary information

- IVD**
- Oral Feeding**
- External Feeding**
- PN**
- Others**
- Urine**
- Aspiration/FF**
- Stoma**
- Others**
- Balance**
- Remarks**

#### STEP 4

Click on the **Add/Update** button to add the information in to Result List

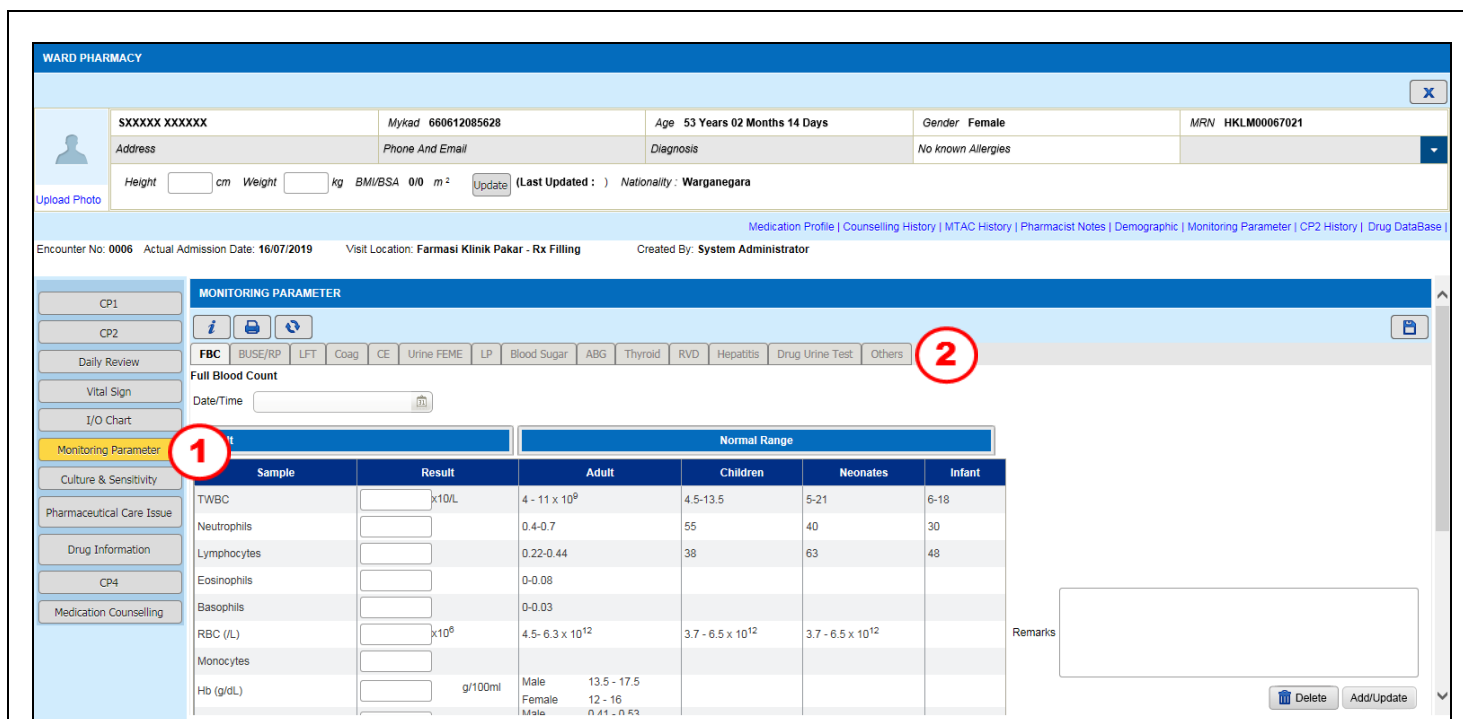
**Note**

- User is allowed to delete the record by click on the  button
- User is allowed to update the record by double click on the information in the Result List and edit the information if applicable



### 3.1.6 Monitoring Parameter

To record Monitoring Parameter, perform the step below:



**WARD PHARMACY**

XXXXXX XXXXXX Mykad 660612085628 Age 53 Years 02 Months 14 Days Gender Female MRN HKLM00067021

Address Phone And Email Diagnosis No known Allergies

Height cm Weight kg BMI/BSA 0/0 m<sup>2</sup> Update (Last Updated : ) Nationality : Warganegara

Encounter No: 0006 Actual Admission Date: 16/07/2019 Visit Location: Farmasi Klinik Pakar - Rx Filling Created By: System Administrator

**MONITORING PARAMETER**

FBX BUSE/RP LFT Coag CE Urine FEME LP Blood Sugar ABG Thyroid RVD Hepatitis Drug Urine Test Others

Full Blood Count

Date/Time

Sample	Result	Adult	Children	Neonates	Infant
TWBC	x10 <sup>9</sup> /L	4 - 11 x 10 <sup>9</sup>	4.5-13.5	5-21	6-18
Neutrophils		0.4-0.7	55	40	30
Lymphocytes		0.22-0.44	38	63	48
Eosinophils		0-0.08			
Basophils		0-0.03			
RBC (L)	x10 <sup>6</sup>	4.5 - 6.3 x 10 <sup>12</sup>	3.7 - 6.5 x 10 <sup>12</sup>	3.7 - 6.5 x 10 <sup>12</sup>	
Monocytes					
Hb (g/dL)	g/100ml	Male 13.5 - 17.5 Female 12 - 16			

Remarks

Delete Add/Update

Figure 3.1.6-1 Lab Parameter

#### STEP 1

Click on the **Monitoring Parameter** tab on the left side

#### STEP 2

Select Lab Parameter that consist of:

- FBX**
- BUSE/RP**
- LFT**
- Coug**
- CE**
- Urine FEME**
- LP**
- Blood Sugar**
- ABG**
- Thyroid**
- RVD**
- Hepatitis**
- Drug Urine Test**
- Others**

MONITORING PARAMETER

FBC

BUSE/RP

LFT

Coag

CE

Urine FEME

LP

Blood Sugar

ABG

Thyroid

RVD

Hepatitis

Drug Urine Test

Others

Full Blood Count

Date/Time

Result		Normal Range			
Sample	Result	Adult	Children	Neonates	Infant
TWBC	<input type="text"/> x10/L	4 - 11 x 10 <sup>9</sup>	4.5-13.5	5-21	6-18
Neutrophils	<input type="text"/>	0.4-0.7	55	40	30
Lymphocytes	<input type="text"/>	0.22-0.44	38	63	48
Eosinophils	<input type="text"/>	0-0.08			
Basophils	<input type="text"/>	0-0.03			
RBC (/L)	<input type="text"/> x10 <sup>6</sup>	4.5- 6.3 x 10 <sup>12</sup>	3.7 - 6.5 x 10 <sup>12</sup>	3.7 - 6.5 x 10 <sup>12</sup>	
Monocytes	<input type="text"/>				
Hb (g/dL)	<input type="text"/> g/100ml	Male 13.5 - 17.5 Female 12 - 16			
HCT	<input type="text"/>	Male 0.41 - 0.53 Female 0.36 - 0.46	0.31 - 0.37	0.28 - 0.55	0.33 - 0.39
Platelet (/L)	<input type="text"/> x10 <sup>9</sup>	150 - 400 x 10 <sup>9</sup>			
MPV	<input type="text"/>				
MCV (fL)	<input type="text"/> fL	80 - 100	76 - 80		70 - 74
MCH (pg/cell)	<input type="text"/>	26 - 34	26-32	29	27
MCHC (g/L)	<input type="text"/>	310 - 370	310 - 370	290 - 380	

3

Remarks

Delete

Add/Update

4

Result List

<<

1

/ 1

>>

Date/Time	TWBC	Neutrophils	Lymphocytes	Eosinophils	Basophils	RBC (/L)	Monocytes	Hb (g/dL)	HCT	Platelet (/L)	MPV	MCV (fL)	MCH (pg/cell)	MCHC (g/L)	Remarks
No Records Found!															

Figure 3.1.6-2 Lab Parameter

## STEP 3

Fill in all necessary information

## STEP 4

Click on the 

Add/Update

 button to add the information in to Result List

## Note

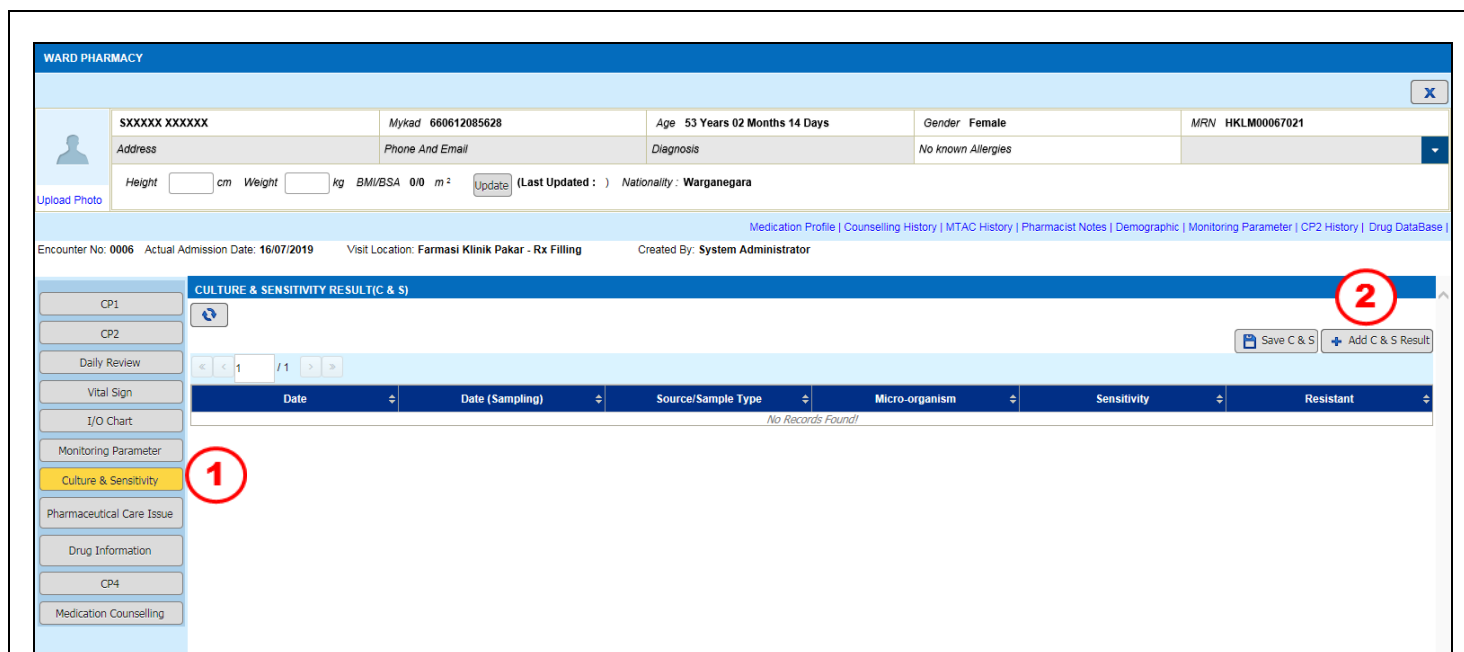
- User is allowed to delete the record by click on the 

Delete

 button
- User is allowed to update the record by double click on the information in the Result List and edit the information if applicable
- The step is the same for all other Lab Parameter

### 3.1.7 Culture & Sensitivity

To record C&S, perform the step below:



**WARD PHARMACY**

XXXXXX XXXXXX Mykad 660612085628 Age 53 Years 02 Months 14 Days Gender Female MRN HKLM00067021

Address Phone And Email Diagnosis No known Allergies

Height cm Weight kg BMI/BSA 0/0 m<sup>2</sup> Update (Last Updated : ) Nationality : Warganegara

Encounter No: 0006 Actual Admission Date: 16/07/2019 Visit Location: Farmasi Klinik Pakar - Rx Filling Created By: System Administrator

**CULTURE & SENSITIVITY RESULT(C & S)**

Save C & S Add C & S Result

Date	Date (Sampling)	Source/Sample Type	Micro-organism	Sensitivity	Resistant
No Records Found!					

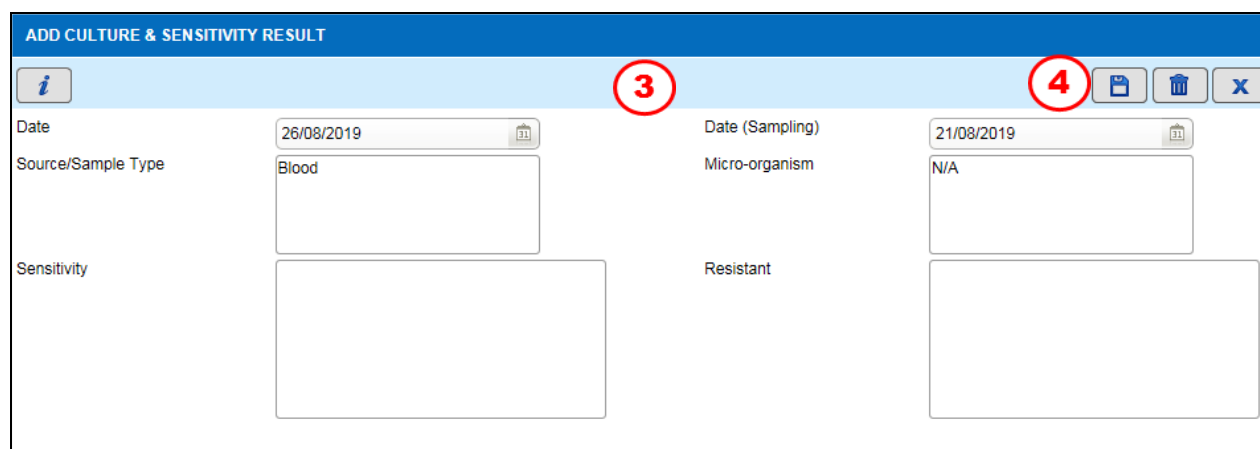
Figure 3.1.7-1 Culture & Sensitivity

#### STEP 1

Click on the **Culture & Sensitivity** tab on the left side

#### STEP 2

Click on the **+ Add C & S Result** button and C&S Result screen will displayed as Figure 3.1.7-2



**ADD CULTURE & SENSITIVITY RESULT**

Date 26/08/2019 Date (Sampling) 21/08/2019

Source/Sample Type Blood Micro-organism N/A

Sensitivity Resistant

Figure 3.1.7-2 Culture & Sensitivity

#### STEP 3

Fill in all the necessary information


- Date**
- Date (Sampling)**
- Source/Sample Type**
- Micro-organism**
- Sensitivity**

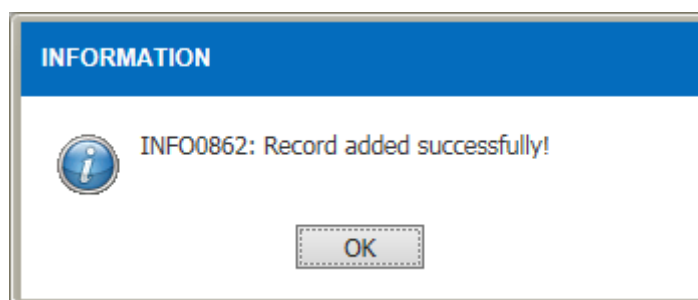
f) **Resistant**

**Note**

user is allow to edit **Date** with the condition of 5 days backdated

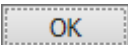
**STEP 4**


Click on the  button to save the record and system will display information alert as Figure 3.1.7-3



**Figure 3.1.7-3 Information Alert**

**Note**

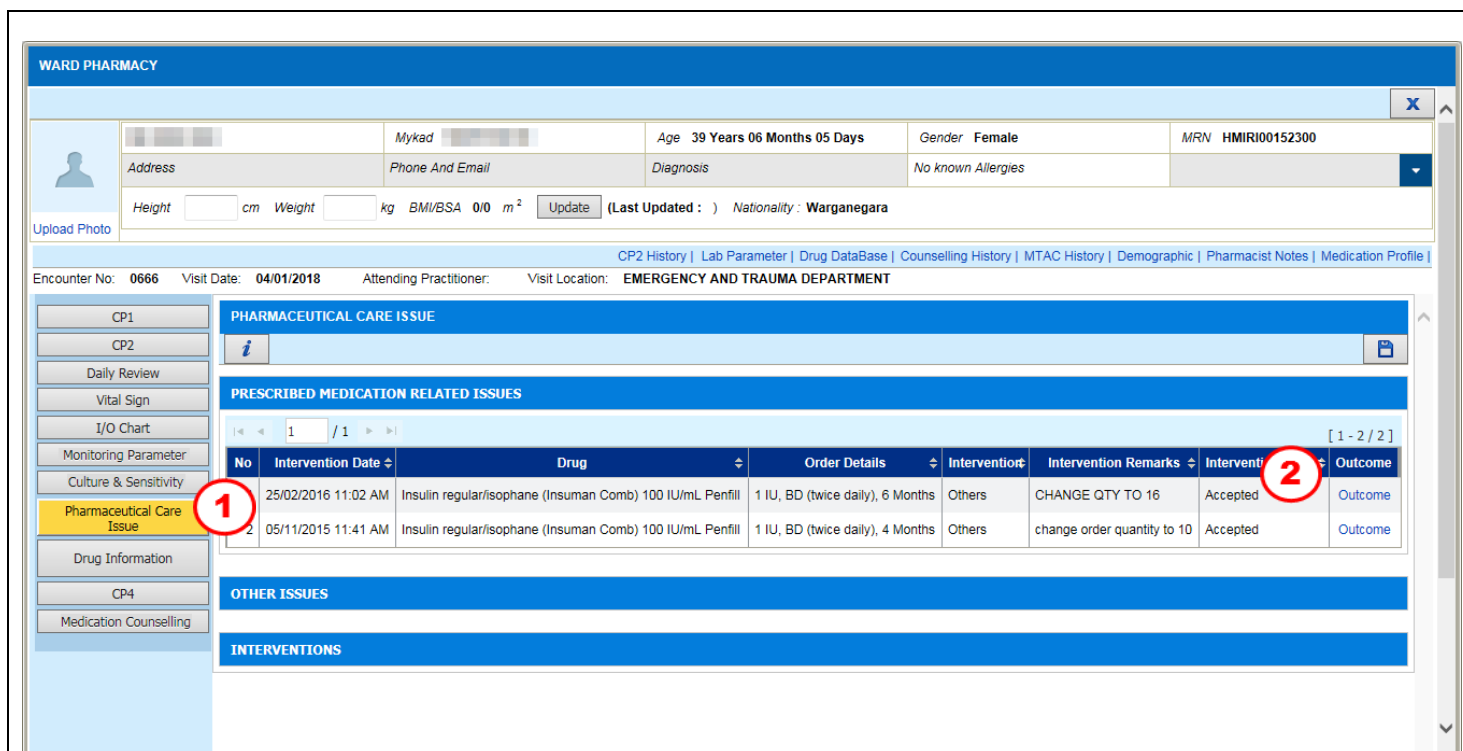
- Click on the  button to successfully save the record
- After saved, the information will be display at the C&S main screen as Figure 3.1.7-4

CULTURE & SENSITIVITY RESULT(C & S)					
<div>  <div>Save C &amp; S Add C &amp; S Result</div> <div> <div>&lt; 1 / 1 &gt;</div> <div>[ 1 - 1 / 1 ]</div> </div> </div>					
Date	Date (Sampling)	Source/Sample Type	Micro-organism	Sensitivity	Resistant
26/08/2019	21/08/2019	Blood	N/A		

**Figure 3.1.7-4 Culture & Sensitivity**

### 3.1.8 Pharmaceutical Care Issue

To record Pharmaceutical Care Issue, perform the step below:



**WARD PHARMACY**

Encounter No: 0666 Visit Date: 04/01/2018 Attending Practitioner: Visit Location: EMERGENCY AND TRAUMA DEPARTMENT

**PHARMACEUTICAL CARE ISSUE**

**PRESCRIBED MEDICATION RELATED ISSUES**

No	Intervention Date	Drug	Order Details	Intervention	Intervention Remarks	Intervention Outcome	Outcome
1	25/02/2016 11:02 AM	Insulin regular/isophane (Insuman Comb) 100 IU/mL Penfill	1 IU, BD (twice daily), 6 Months	Others	CHANGE QTY TO 16	Accepted	Outcome
2	05/11/2015 11:41 AM	Insulin regular/isophane (Insuman Comb) 100 IU/mL Penfill	1 IU, BD (twice daily), 4 Months	Others	change order quantity to 10	Accepted	Outcome

**OTHER ISSUES**

**INTERVENTIONS**

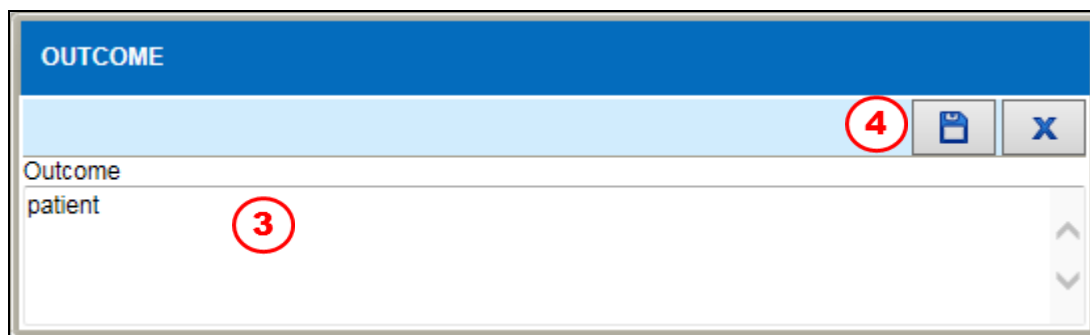
Figure 3.1.8-1 Pharmaceutical Care Issue

#### STEP 1

Click on the **Pharmaceutical Care Issue** tab on the left side

#### STEP 2

Enter the **Prescribed Medication Related Issues** if applicable by click on the **Outcome** hyperlink



**OUTCOME**

Outcome  
patient

Figure 3.1.8-2 Outcome

#### STEP 3

Enter the information **outcome**

#### STEP 4

Click on the  button to save the record

### Note

**Prescribed Medication Related Issues** is only available if pharmacists do the prescription intervention during dispensing stage

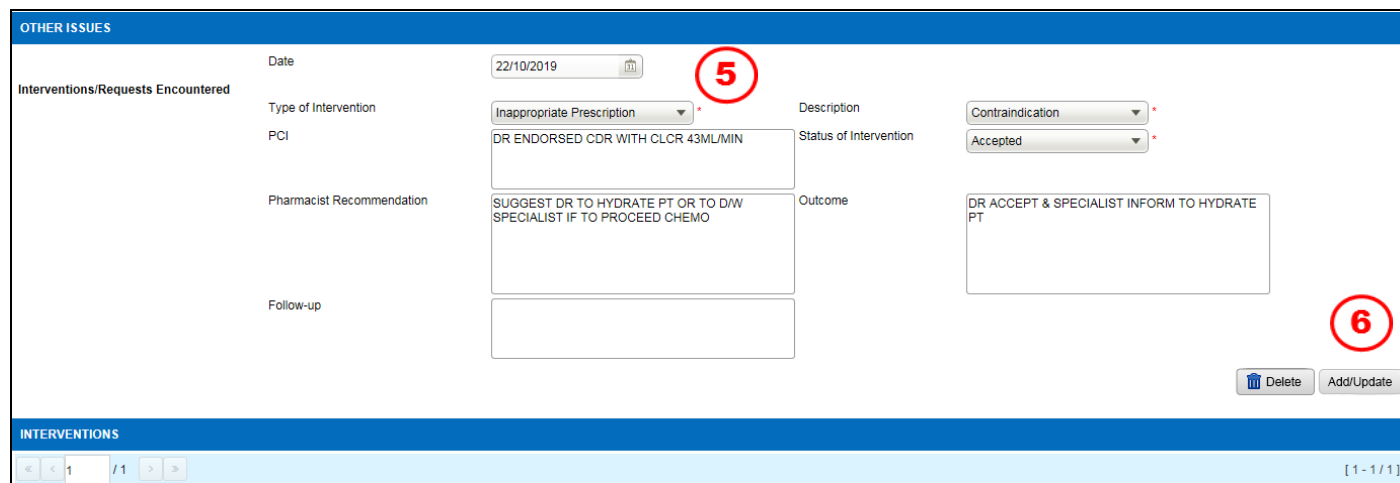


Figure 3.1.8-3 Other Issues

### STEP 5

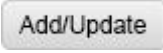
Enter '**Other Issues**' if applicable

- a) **Date**
- b) **Type of Intervention**
  - **Inappropriate Prescription**
  - **Incomplete Prescriptions**
  - **Incorrect/Inappropriate/Inadequate Regimen**
  - **Miscellaneous**
- c) **PCI**
- d) **Pharmacist Recommendation**
- e) **Description**
  - **Contraindication**
  - **Drug Interaction**
  - **Incompatibility**
  - **Polypharmacy**
- f) **Status of Intervention**
  - **Accepted**
  - **Not Accepted**
  - **Not Available**
- g) **Outcome**
- h) **Follow-up**

### Note

This section is use for ward pharmacist to record other PCI issue that is not related to dispensing intervention.

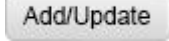

### STEP 6

Click on the  button to add the record and it will display in Interventions section as Figure 3.1.8-4

INTERVENTIONS								
<div> <div>1 / 1</div> <div>[1 - 1 / 1]</div> </div>								
Date	Type of Intervention	Description	PCI	Pharmacist Recommendation	Status of Intervention	Outcome	Follow-up	Check list
22/10/2019	Inappropriate Prescription	Contraindication	DR ENDORSED CDR WITH CLCR 43ML/MIN	SUGGEST DR TO HYDRATE PT OR TO D/W SPECIALIST IF TO PROCEED CHEMO	Accepted	DR ACCEPT & SPECIALIST INFORM TO HYDRATE PT		<input type="checkbox"/>

Figure 3.1.8-4 Interventions

### Note

- To edit information in '**Interventions**' section, double click on the data then click on the  button. Change the information that display in the '**Other Issue**' section.
- To delete information in '**Interventions**' section, click on the information checkbox then click on the  button.

PHARMACEUTICAL CARE ISSUE

i

7

PRESCRIBED MEDICATION RELATED ISSUES

1 / 1

[1 - 2 / 2]

No	Intervention Date	Drug	Order Details	Intervention	Intervention Remarks	Intervention Status	Outcome
1	25/02/2016 11:02 AM	Insulin regular/isophane (Insuman Comb) 100 IU/mL Penfill	1 IU, BD (twice daily), 6 Months	Others	CHANGE QTY TO 16	Accepted	Outcome
2	05/11/2015 11:41 AM	Insulin regular/isophane (Insuman Comb) 100 IU/mL Penfill	1 IU, BD (twice daily), 4 Months	Others	change order quantity to 10	Accepted	Outcome

OTHER ISSUES

INTERVENTIONS

Figure 3.1.8-5 Pharmaceutical Care Issue

### STEP 7

Click on the  button to save the record and system will displayed confirmation alert as Figure 3.1.8-6

CONFIRMATION

?

CONF0002: Are you sure you want to save?

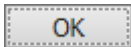
Cancel

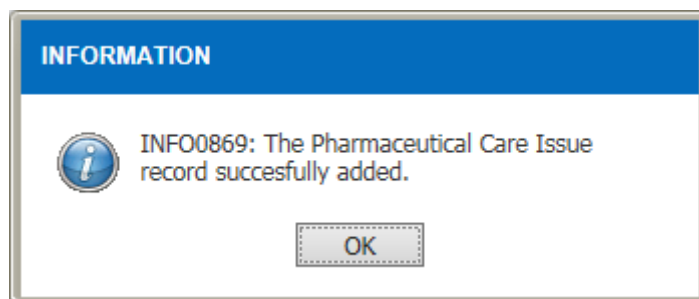
Yes

No

Figure 3.1.8-6 Confirmation Alert

### Note

Click on the  button to save the record and system will display information alert as Figure 3.1.8-7



**Figure 3.1.8-7 Information Alert**

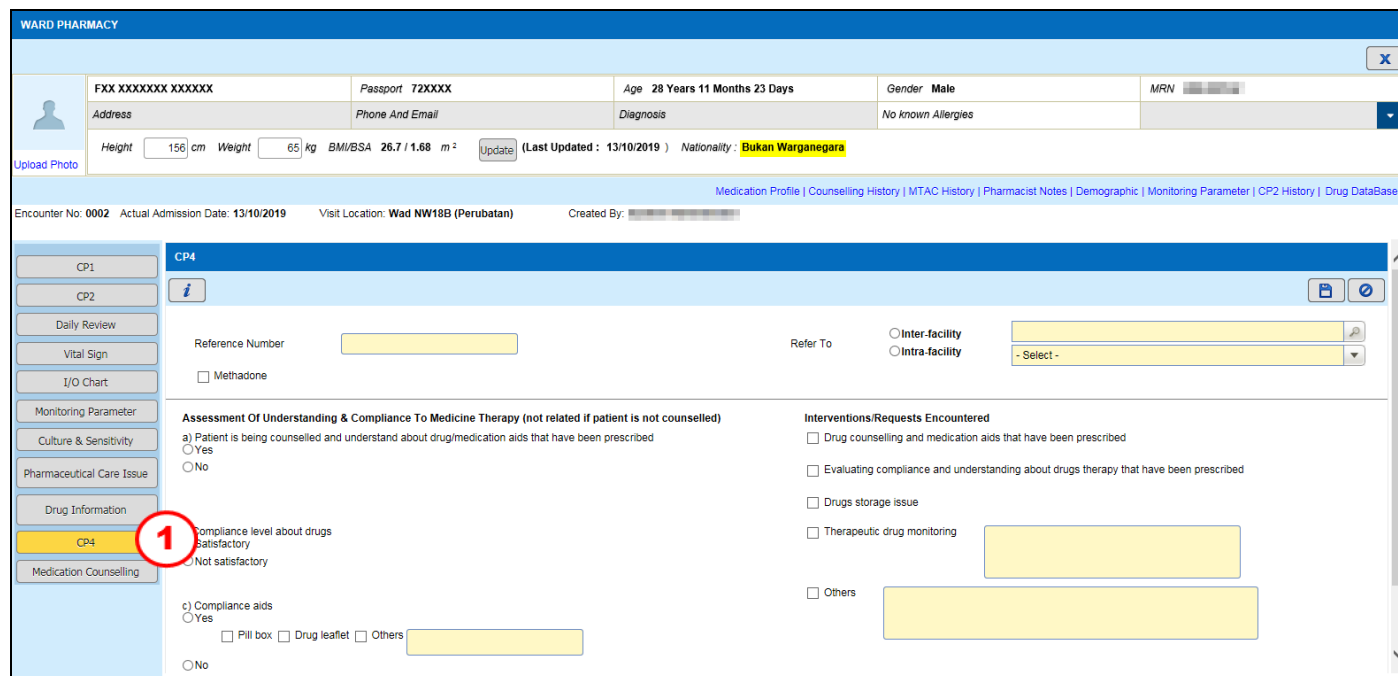
**Note**

Click on the  button to successfully save



## 3.1.9 CP4

To record CP4, perform the step below:



**WARD PHARMACY**

Encounter No: 0002 Actual Admission Date: 13/10/2019 Visit Location: Wad NW18B (Perubatan) Created By: [User Name]

**CP4**

Reference Number: [Field]  
☐ Methadone

Assessment Of Understanding & Compliance To Medicine Therapy (not related if patient is not counselled)

a) Patient is being counselled and understand about drug/medication aids that have been prescribed  
☐ Yes  
☐ No

b) Compliance level about drugs  
☐ Satisfactory  
☐ Not satisfactory

c) Compliance aids  
☐ Yes  
☐ Pill box ☐ Drug leaflet ☐ Others [Field]  
☐ No

Interventions/Requests Encountered

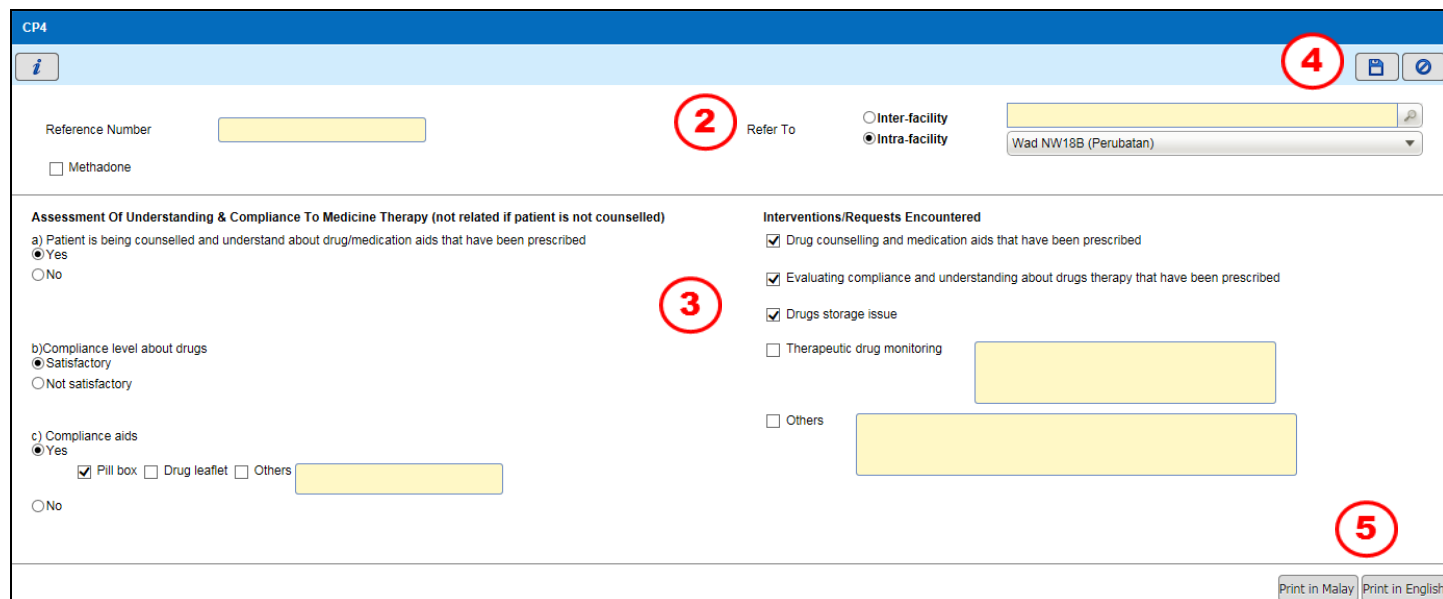
☐ Drug counselling and medication aids that have been prescribed  
☐ Evaluating compliance and understanding about drugs therapy that have been prescribed  
☐ Drugs storage issue  
☐ Therapeutic drug monitoring [Field]  
☐ Others [Field]

Figure 3.1.9-1 CP4

### STEP 1

Click on the **CP4** tab on the left side

## To Record CP4



The screenshot shows the CP4 form interface. Callout 2 points to the 'Refer To' section with radio buttons for 'Inter-facility' and 'Intra-facility'. Callout 3 points to the 'Assessment Of Understanding & Compliance To Medicine Therapy' section, which includes questions about patient counseling, compliance level, and compliance aids. Callout 4 points to the top right of the form, and callout 5 points to the 'Print in Malay' and 'Print in English' buttons at the bottom right.

Figure 3.1.9-2 CP4

### STEP 2


Select **Refer To**

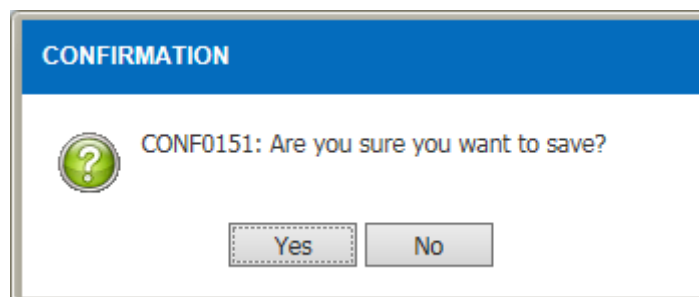
- a) **Inter-facility**
- b) **Intra-facility**

### STEP 3

Fill up the question

### STEP 4

Click on the  button to save the record



A confirmation alert dialog box with a blue header titled 'CONFIRMATION'. It contains a question mark icon and the text 'CONF0151: Are you sure you want to save?'. At the bottom, there are two buttons: 'Yes' and 'No'.

Figure 3.1.9-3 Confirmation Alert

### Note

Click on the  button to save the record

### STEP 5

Click on  the button to print in Malay and  button to print in English

**KEMENTERIAN KESIHATAN MALAYSIA**  
**HOSPITAL KUALA LUMPUR**  
**Jabatan Farmasi**

**NOTA RUJUKAN**

**CP4/411**

---

**KEPADA:**  
 Pegawai Perubatan/Pegawai Farmasi : Wad SW26 (Perubatan)  
 PER: RUJUKAN PESAKIT

MXXXXXXX XXXX  
 NAMA

/      /      /  
 MRN

/      /      /  
 NO. KP

Pesakit ini TELAH / ~~BEUM~~ DIBERI KAUNSELING UBAT-UBATAN untuk dinilai tahap kefahaman/kepatuhan terhadap terapi ubat yang ditetapkan. Diharapkan pihak tuan/puan dapat memberi kaunseling dan penilaian susulan yang diperlukan untuk meningkatkan keberkesanan rawatan.

**2. DIAGNOSIS :**  
 None

**3. SENARAI UBAT SEMASA:**

Nama Ubat	Dos	Frekuensi	Tarikh Mula	Tarikh Tamat	Jangkamasa Bekalan

**4. PENILAIAN KEFAHAMAN & KEPATUHAN TERHADAP TERAPI UBAT**  
 (Tidak berkenaan jika pesakit belum dikaunsel)

a) Pesakit telah dikaunsel dan faham tentang ubat/alat bantuan pengubatan yang ditetapkan ☒ Ya ☐ Tidak

b) Tahap kepatuhan terhadap ubat - ubatan ☒ Memuaskan ☐ Tidak Memuaskan

c) Alat bantuan kepatuhan ☐ Pill Box ☐ Risalah Ubat ☐ Lain - lain ☒ Tidak

**5. TINDAKAN SUSULAN YANG DIPERLUKAN**  
 [Sila tandakan ( ☒ ) di kotak yang disediakan]

<input checked="" type="checkbox"/>	Kaunseling ubat - ubat dan alat bantuan pengubatan yang ditetapkan
<input type="checkbox"/>	Menilai kepatuhan dan kefahaman terhadap terapi ubat yang ditetapkan
<input type="checkbox"/>	Pemantauan ubat terapeutik:
<input type="checkbox"/>	Isu penyimpanan ubat - ubatan
<input type="checkbox"/>	Lain - lain:

Sekian, terima kasih.

PF44  
 0326155555  
 30/10/2019

Figure 3.1.9-4 Print In Malay

**KEMENTERIAN KESIHATAN MALAYSIA**  
**HOSPITAL KUALA LUMPUR**  
**Pharmacy Department**

REFERRAL NOTE

CP4/413

---

TO:  
Medical Officer / Pharmacist : Wad SW27 (Perubatan)

RE: PATIENT REFERRAL

NX XXXX XXXX  
Name

/

MRN

/

IC No

This patient HAS / ~~NOT~~ BEEN GIVEN MEDICATION COUNSELING for understanding of the treatment that have been prescribed. We expect that you can give the counselling & further evaluation that needed to increase the effectiveness of the treatment.

2. DIAGNOSIS :  
None

3. LIST OF CURRENT DRUG :

Drug Name	Dose	Frequency	Start Date	End Date	Supply Period

4. UNDERSTANDING ASSESSMENT & COMPLIANCE TO DRUG  
(not applicable if the patient has not been counseled):

a) The patient has been counseled and understand the drug/medication aids prescribed ☒ Yes ☐ No

b) Compliance level about Drugs ☐ Satisfactory ☐ Not-Satisfactory

c) Compliance Aids ☐ Pill Box ☐ Drug Message ☐ Others ☐ No

5. INFORMATION / REQUESTS ENCOUNTERED :

[Please tick ( ☒ ) In the box provided]

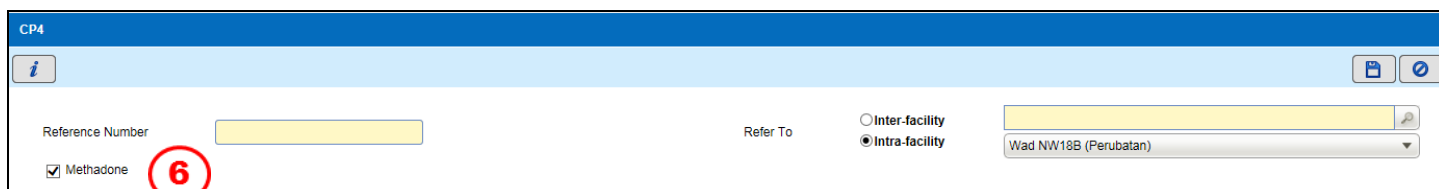
	Drug counselling and medication aids that have been prescribed
<input checked="" type="checkbox"/>	Evaluate compliance with and understanding of the prescribed drug therapy
	Therapeutic drug monitoring:
	Drug storage issues
	Other:

Thank You,

PF44  
0326155555  
30/10/2019

Figure 3.1.9-5 Print In English

## To Record CP4 Methadone



CP4

Reference Number

Refer To ☐ Inter-facility ☒ Intra-facility

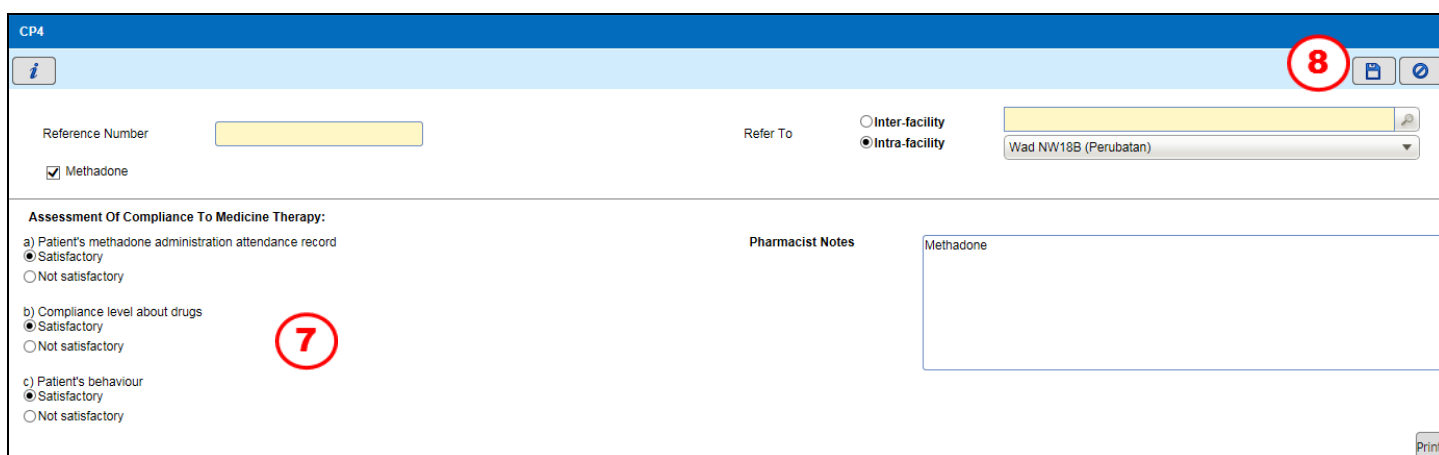
☒ Methadone

Wad NW18B (Perubatan)

Figure 3.1.9-6 CP4 Methadone

### STEP 6

Click on the **Methadone** checkbox



CP4

Reference Number

Refer To ☐ Inter-facility ☒ Intra-facility

☒ Methadone

Wad NW18B (Perubatan)

Assessment Of Compliance To Medicine Therapy:

a) Patient's methadone administration attendance record

☒ Satisfactory

☐ Not satisfactory

b) Compliance level about drugs

☒ Satisfactory

☐ Not satisfactory

c) Patient's behaviour

☒ Satisfactory

☐ Not satisfactory

Pharmacist Notes

Methadone

Print

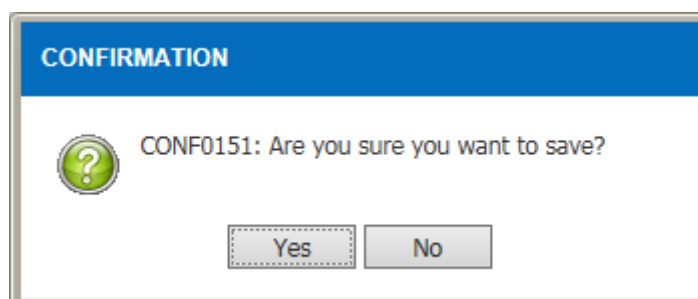
Figure 3.1.9-7 CP4 Methadone

### STEP 7

Fill up the question

### STEP 8

Click on the  button to save the record



CONFIRMATION

CONF0151: Are you sure you want to save?

Yes No

Figure 3.1.9-8 Confirmation Alert

### Note

- Click on the  button to save the record

- Click on  the button to view/print report

**KEMENTERIAN KESIHATAN MALAYSIA**  
**HOSPITAL KUALA LUMPUR**  
**Jabatan Farmasi**

---

**NOTA RUJUKAN:** METHADONE CP4/413

**KEPADA:**  
Pegawai Perubatan/Pegawai Farmasi : Wad SW27 (Perubatan)

**PER: RUJUKAN**

NX XXXX XXXX  
 NAMA

/   
 MRN

/   
 NO.KP

Pesakit ini TELAH/BELUM DIBERI KAUNSELING UBAT-UBATAN untuk dinilai tahap kefahaman/kepatuhan terhadap terapi ubat yang dipreskripsikan. Diharapkan pihak tuan/puan dapat memberi kaunseling dan penilaian susulan yang diperlukan untuk meningkatkan keberkesanan rawatan.

**2. SENARAI UBAT / REKOD-REKOD UBATAN LAIN:**

NAMA UBAT	DOS	TEMPOH BEKALAN

**3. KEPATUHAN TERHADAP TERAPI UBAT**

a) Rekod kedatangan pesakit mengambil	<input checked="" type="checkbox"/>	Memuaskan	<input type="checkbox"/>	Tidak Memuaskan
b) Tahap kepatuhan terhadap ubat-ubatan	<input checked="" type="checkbox"/>	Memuaskan	<input type="checkbox"/>	Tidak Memuaskan
c) Tingkahlaku pesakit	<input checked="" type="checkbox"/>	Memuaskan	<input type="checkbox"/>	Tidak Memuaskan

**CATATAN PEGAWAI FARMASI**  
 None

Cop & Tandatangan Pegawai Farmasi

No. Tel:

Tarikh : 30/10/2019 BAHAGIAN PERKHIDMATAN FARMASI, KKM

Figure 3.1.9-9 CP4 Report

## 4.0 Acronyms

Abbreviation	Definition
PhIS	Pharmacy Information System
CPS	Clinical Pharmacy System
PM	Patient Management
eGL	Electronic Guarantee Letter
HRMIS	Human Resource Management System
MRN	Medical Record Number
MOH	Ministry of Health

## 5.0 Links to Clinical Modules

No	Module	PDF Links	No	Module	PDF Links
1	Inpatient	<a href="#">Click Here</a>	12	CDR Dispensing	<a href="#">Click Here</a>
2	CDR Order	<a href="#">Click Here</a>	13	Methadone Dispensing	<a href="#">Click Here</a>
3	TDM Order	<a href="#">Click Here</a>	14	PN Dispensing	<a href="#">Click Here</a>
4	PN Order	<a href="#">Click Here</a>	15	Order Management	<a href="#">Click Here</a>
5	IV Order	<a href="#">Click Here</a>	16	Patient Management	<a href="#">Click Here</a>
6	Prepacking	<a href="#">Click Here</a>	17	Radiopharmaceuticals	<a href="#">Click Here</a>
7	Galenical	<a href="#">Click Here</a>	18	Outpatient	<a href="#">Click Here</a>
8	MTAC	<a href="#">Click Here</a>	19	Special Drug Request	<a href="#">Click Here</a>
9	ADR & DAC	<a href="#">Click Here</a>	20	MAR	<a href="#">Click Here</a>
10	Medication Counselling	<a href="#">Click Here</a>	21	DICE	<a href="#">Click Here</a>
11	Ward Pharmacy	<a href="#">Click Here</a>	22		