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| --- | --- | --- | --- | --- | --- | --- |
| **Topical Cream Administration Record** | Sheet |  | Of |  | Start date: |  |
| **Photo** | Name: |  | GP Name |  |
| Date of Birth: |  | Surgery |  |
| Address: |  | NHS No. |  |
| **Allergies:** |  |
| Key: | R = Refused, H = Hospital, N = Nausea / Vomit, X = Not Given, O = Other |
| **Medication Details** |
|  |
| **Highlight below where cream is to be administered** |
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|  | **Week 1** | **Week 2** | **Week 3** | **Week 4** |
| **Date** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Morning** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Lunch** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Tea** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Bed** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Completed | Approved | Quantity received: |  | Carried forward: |  | Returned: |  |
| by | by | Sign | Date | Sign | Date |

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| **Date** | **Time** | **Detail of Notes** | **Name:** | **Sign:** |
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