|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | ‘AS REQUIRED’ (PRN) SUBCUTANEOUS INJECTIONS Developed for any patient who requires their medications delivered via syringe pump When transferring care confirm current drugs and doses using syringe pump infusion administration record. This document should remain with the patient. | | | | | | | | | | *[Insert organisation  logo C:\Users\McGinnM\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\98Q6BPSV\NHS-RGB.jpghere]* | | | | | |
| Patient Name: |  | | | |  | Allergies and adverse drug reactions | | | | | | | | | | |
| DOB: |  | | | |  | no known allergies | | | | | | | | | | |
| NHS Number: |  | | | |  | Medicine / substance: | | | | | | Reaction: | | | | |
|  |  | | | |  | Prescriber sign & print: | | | | | | | | | | |
| CONTACT THE PALLIATIVE CARE TEAM FOR ADVICE AS REQUIRED  |  |  | | --- | --- | | **Prescriber contact details:** |  | | | | | | | | | | | | | | | | | |
| Pain | | | | Date: | | |  |  |  |  | | |  |  |  |  |
| Medication: | | | | Time: | | |  |  |  |  | | |  |  |  |  |
| Dose range: | | Max frequency: | Subcut | Dose: | | |  |  |  |  | | |  |  |  |  |
| Prescriber sign, print & date: | | | | Sign: | | |  |  |  |  | | |  |  |  |  |
| Nausea / Vomiting | | | | Date: | | |  |  |  |  | | |  |  |  |  |
| Medication: | | | | Time: | | |  |  |  |  | | |  |  |  |  |
| Dose range: | | Max frequency: | Subcut | Dose: | | |  |  |  |  | | |  |  |  |  |
|  | | Max 24hr dose: |  |  | | |  |  |  |  | | |  |  |  |  |
| Prescriber sign, print & date: | | | | Sign: | | |  |  |  |  | | |  |  |  |  |
| Agitation / Distress | | | | Date: | | |  |  |  |  | | |  |  |  |  |
| Medication: | | | | Time: | | |  |  |  |  | | |  |  |  |  |
| Dose range: | | Max frequency: | Subcut | Dose: | | |  |  |  |  | | |  |  |  |  |
|  | | Max 24hr dose: |  |  | | |  |  |  |  | | |  |  |  |  |
| Prescriber sign, print & date: | | | | Sign: | | |  |  |  |  | | |  |  |  |  |
| Respiratory tract secretions | | | | Date: | | |  |  |  |  | | |  |  |  |  |
| Medication: | | | | Time: | | |  |  |  |  | | |  |  |  |  |
| Dose range: | | Max frequency: | Subcut | Dose: | | |  |  |  |  | | |  |  |  |  |
|  | | Max 24hr dose: |  |  | | |  |  |  |  | | |  |  |  |  |
| Prescriber sign, print & date: | | | | Sign: | | |  |  |  |  | | |  |  |  |  |
| Other – specify indication here: | | | | Date: | | |  |  |  |  | | |  |  |  |  |
| Medication: | | | | Time: | | |  |  |  |  | | |  |  |  |  |
| Dose range: | | Max frequency: | Subcut | Dose: | | |  |  |  |  | | |  |  |  |  |
|  | | Max 24hr dose: |  |  | | |  |  |  |  | | |  |  |  |  |
| Prescriber sign, print & date: | | | | Sign: | | |  |  |  |  | | |  |  |  |  |
| Other – specify indication here: | | | | Date: | | |  |  |  |  | | |  |  |  |  |
| Medication: | | | | Time: | | |  |  |  |  | | |  |  |  |  |
| Dose range: | | Max frequency: | Subcut | Dose: | | |  |  |  |  | | |  |  |  |  |
|  | | Max 24hr dose: |  |  | | |  |  |  |  | | |  |  |  |  |
| Prescriber sign, print & date: | | | | Sign: | | |  |  |  |  | | |  |  |  |  |
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