*[Insert organisation logo here]*

# CONTINUOUS SUBCUTANEOUS INFUSION FROM A SYRINGE PUMP

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.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Name: | |  | |  | Allergies and adverse drug reactions | | | |
| DOB: | |  | |  | no known allergies | | | |
| NHS Number: | |  | |  | Medicine / substance: | | | Reaction: |
| Doses are for administration over 24 hours.  For shorter infusion periods strike through above and state here: Doses are for administration over       hours | | | |  | Prescriber sign & print: | | | |
| CONTACT THE PALLIATIVE CARE TEAM FOR ADVICE AS REQUIRED  |  |  | | --- | --- | | **Prescriber contact details:** |  | | | | | | | | | |
| Pain | | | | | | | | |
| Date: | Medication: | | Dose range: | | | Prescriber sign & print: | | |
| Nausea / Vomiting | | | | | | | | |
| Date: | Medication: | | Dose range: | | | Prescriber sign & print: | | |
| Agitation / Distress | | | | | | | | |
| Date: | Medication: | | Dose range: | | | Prescriber sign & print: | | |
| Respiratory tract secretions | | | | | | | | |
| Date: | Medication: | | Dose range: | | | Prescriber sign & print: | | |
| Other medication – specify indication here: | | | | | | | | |
| Date: | Medication: | | Dose range: | | | Prescriber sign & print: | | |
| Other medication – specify indication here: | | | | | | | | |
| Date: | Medication: | | Dose range: | | | Prescriber sign & print: | | |
| DILUENT | | | | | | | | |
| Date: | Diluent: | | | | | | Prescriber sign & print: | |