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|  | | REGULAR AND SINGLE (“STAT”) DOSE SUBCUTANEOUS  AND INTRAMUSCULAR 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 hC:\Users\McGinnM\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\98Q6BPSV\NHS-RGB.jpgere]* | | | |
| 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:** |  |  REGULAR DOSE SUBCUTANEOUS INJECTIONS | | | | | | | | | | | | | | | | | | |
| Specify indication here: | | | | Date: | |  | | |  |  |  |  | |  | |  |  |  |
| Medication: | | | | Enter administration times |  |  | | |  |  |  |  | |  | |  |  |  |
| Dose range: | | | Subcut |  |  |  | | |  |  |  |  | |  | |  |  |  |
| Prescriber sign, print & date: | | | |  |  |  | | |  |  |  |  | |  | |  |  |  |
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| Specify indication here: | | | | Date: | |  | | |  |  |  |  | |  | |  |  |  |
| Medication: | | | | Enter administration times |  |  | | |  |  |  |  | |  | |  |  |  |
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| Prescriber sign, print & date: | | | |  |  |  | | |  |  |  |  | |  | |  |  |  |
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## SINGLE (“STAT”) DOSE SUBCUTANEOUS OR INTRAMUSCULAR INJECTIONS

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| Specify indication here: | | Administration record: | |
| Medication: | |  | |
| Date to be administered: | | Date: |  |
| Time to be administered: | | Time: |  |
| Dose: | Route: | Dose: |  |
| Prescriber sign, print & date: | | Sign: |  |
| Specify indication here: | | Administration record: | |
| Medication: | |  | |
| Date to be administered: | | Date: |  |
| Time to be administered: | | Time: |  |
| Dose: | Route: | Dose: |  |
| Prescriber sign, print & date: | | Sign: |  |