*[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:      |