Authorisation for administration of medicine by Community Nurses For the Care of the Dying Patient

*Please refer to attached guidelines for advice.

Patients name: Address: Allergies: Date of completion:	D.O.B: NHS Number: GP: Review date:

MEDICATION PRESCRIBED FOR SYRINGE DRIVER OVER 24 HOURS

SYMPTOM	MEDICATION (Generic Name)	STARTING DOSE	RANGE (The community nurse will be able to amend the syringe driver without it being re-prescribed if you indicate below a set increment for dose increase and a maximum dose. If no increase is suitable please state 'none')	DR / NMP NAME Please print & Regulatory Body PIN	DR / NMP SIGNATURE and DATE
Pain					
Nausea & vomiting					
Agitation					
Respiratory tract secretions					
Breathlessness					

Diluent for syringe driver	Water for injection / Sodium Chloride 0.9% (delete as appropriate)		

MEDICATION FOR INTERVAL (PRN) DOSES

SYMPTOM	MEDICATION (Generic name)	DILUENT FOR MEDICATION (if required)	DOSE AND ROUTE	DOSING FREQUENCY (to include maximum frequency)	DR / NMP NAME Please print & Regulatory Body PIN	DR / NMP SIGNATURE and DATE
Pain						
Nausea & vomiting						
Agitation						
Respiratory tract secretions						
Breathlessness						

PLEASE NOTE THAT NO MORE THAN 3 PRN DOSES OF ANY DRUG SHOULD BE GIVEN WITHOUT CONSULTING WITH THE PRESCRIBER. SEEK SPECIALIST ADVICE IF UNSURE, CONTACT SINGLEPOINT TEL NUMBER 01206 890360