**Authorisation for Administration of Medication by ESNEFT Community Nurses**

|  |  |  |
| --- | --- | --- |
| **Patient’s name:** | **D.O.B:** | |
| **GP/Clinician:** | **NHS number:** | |
| **ALLERGIES (inc details):** | | **Patient’s address:** |
| **Patient currently on syringe pump? Yes/ No** **If Yes, complete sections A and B** **If No, consider completing section B**    **THIS AUTHORISATION IS ONLY VALID FOR 6 MONTHS DO NOT CHANGE DOSES WRITTEN BY ANOTHER HCP - ALWAYS COMPLETE A NEW FORM** | | |

**A: FOR INFORMATION ONLY - MEDICATION IN SYRINGE PUMP ON INITIATION/DISCHARGE**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date/time commenced** | **Medication name** | **Dose** | **Indication** |
|  |  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**B: MEDICATION FOR SYRINGE PUMP OVER 24 HOURS IF REQUIRED**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Symptom** | **Medication**  **(generic name)** | **Starting dose** | **Range if appropriate** | | **Print name and GMC No./NMC pin** | **Signature and date** |
| **Daily dose increase** | **Upper limit** |
| **Pain** |  |  |  |  |  |  |
| **Nausea & vomiting** |  |  |  |  |  |  |
| **Agitation/distress** |  |  |  |  |  |  |
| **Respiratory tract secretions** |  |  |  |  |  |  |
| **Breathlessness** |  |  |  |  |  |  |
| **Agitation – 2nd line – ask SinglePoint for advice before adding** |  |  |  |  |  |  |
| **Diluent** |  | **-** | **-** | **-** |  |  |

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|  |  |  |
| --- | --- | --- |
| **Patient’s name:** | | **D.O.B:** |
| **NHS number:** | **Patient’s address:** | |
| **ALLERGIES (inc details):** | | |

**C: MEDICATION FOR SUBCUTANEOUS INTERVAL (PRN) DOSES**

**PLEASE NOTE THAT IF MORE THAN 3 PRN DOSES OF ANY DRUG ARE GIVEN IN 24 HRS THEN STAFF MUST CONSULT WITH A PRESCRIBER**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Symptom** | **Medication**  **(generic name)** | **Dose** | **Frequency** | **Maximum amount that can be given over 24 hours** | **Print name and GMC No./NMC pin** | **Signature and date** |
| **Pain** |  |  |  |  |  |  |
| **Nausea & vomiting** |  |  |  |  |  |  |
| **Agitation/distress** |  |  |  |  |  |  |
| **Agitation**  **2nd line – only if needed: ask SinglePoint for advice** |  |  |  |  |  |  |
| **Respiratory tract secretions** |  |  |  |  |  |  |
| **Breathlessness** |  |  |  |  |  |  |
| **Other, e.g. 2nd antiemetic, in case of a bleed/fit** |  |  |  |  |  |  |
| **Diluent**  **(**DIAMORPHINE only**)** | Water for injection |  | **-** | **-** |  |  |

|  |
| --- |
| **Any additional instructions from prescriber/specialist team:** |
| **SEEK SPECIALIST ADVICE IF NEEDED, FOR EXAMPLE IF SYMPTOMS ARE UNCONTROLLED AND DOSES NEED INCREASING, VIA SINGLEPOINT (01206) 890360. A SPECIALIST COMMUNITY/ON CALL DOCTOR IS ALWAYS AVAILABLE FOR ADVICE.** |
| Pharmacy check (name/date): |