RM Partners
Accountable Cancer Network

'AS REQUIRED' (PRN) SUBCUTANEOUS INJECTIONS

Developed for any patient who requires their medications delivered via syringe pump

[Insert organisation logo here]

When transferring care confirm <u>current</u> drugs and doses using syringe pump infusion administration record. This document should remain with the patient.

Patient Name:	
DOB:	
NHS Number:	

Allergies and adverse drug reactions	
☐ no known allergies	
Medicine / substance:	Reaction:
Prescriber sign & print:	

CONTACT THE PALLIATIVE CARE TEAM FOR ADVICE AS REQUIRED

Prescriber contact details:	

Pain			Date:								
Medication:			Time:								
Dose range:	Max frequency:	Subcut ☐	Dose:								
Prescriber sign, print & date:			Sign:								
Nausea / Vomiting			Date:								
Medication:			Time:								
Dose range:	Max frequency: Max 24hr dose:	Subcut ☐	Dose:								
Prescriber sign, print & date:			Sign:								
Agitation / Distress			Date:								
Medication:			Time:								
Dose range:	Max frequency: Max 24hr dose:	Subcut ☐	Dose:								
Prescriber sign, print & date:			Sign:								
Respiratory tract secretions			Date:								
Medication:			Time:								
Dose range:	Max frequency: Max 24hr dose:	Subcut ☐	Dose:								
Prescriber sign, print & date:			Sign:								
Other – specify indication here:			Date:								
Medication:			Time:								
Dose range:	Max frequency: Max 24hr dose:	Subcut ☐	Dose:								
Prescriber sign, print & date:			Sign:								
Other – specify indication here:			Date:								
Medication:			Time:								
Dose range:	Max frequency: Max 24hr dose:	Subcut ☐	Dose:								
Prescriber sign, print & date:			Sign:								