Authority for Administration of Prescribed Medication via

CONTINUOUS SUBCUTANEOUS INFUSION

Infusion No. …… of ……….. Use one page per syringe driver

Patient Name:	Known Allergies / Sensitivities:
NHI:	GP Address:
D.O.B:	

Date	Drug(s)	24 hour dosage (or dose range for each drug)	Prescribed by (name and signature for each drug)	Date Stopped	Stopped by
	1. ____ 2. ____ 3. ____	____ ____ ____	____ ____ ____		

Remember to also prescribe as required (prn) medications to manage breakthrough symptoms

Discontinue infusion by scoring through whole box, dating and signing.
If you wish to change the prescription and/or dose stop current infusion and write new prescription in boxes below.

Date	Drug(s)	24 hour dosage (or dose range for each drug)	Prescribed by (name and signature for each drug)	Date Stopped	Stopped by
	1. ____ 2. ____ 3. ____	____ ____ ____	____ ____ ____		

Date	Drug(s)	24 hour dosage (or dose range for each drug)	Prescribed by (name and signature for each drug)	Date Stopped	Stopped by
	1. ____ 2. ____ 3. ____	____ ____ ____	____ ____ ____		

Date	Drug(s)	24 hour dosage (or dose range for each drug)	Prescribed by (name and signature for each drug)	Date Stopped	Stopped by
	1. ____ 2. ____ 3. ____	____ ____ ____	____ ____ ____		

This chart should be retained in the patient's notes

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