CONTINUOUS SUBCUTANEOUS INFUSION MEDICATION ADMINISTRATION RECORD

DRUG ALLERGIES & SENSITIVITIES

PLEASE CIRCLE AS APPROPRIATE:

NONE KNOWN **YES**

SIGNED.....DATE.....

NAME.....

Drug/Allergen:	Description of reaction

This section must usually be completed prior to administration of any medicine. Refer to local policies for further guidance.

HEALTH RECORD No:_____

SURNAME:_____

FIRST NAME: _____

ADDRESS: _____

_____

DATE OF BIRTH:_____

CONSULTANT/GP_____

DATE OF ADMISSION_____

HOSPITAL _____

WARD_____

DISTRICT NURSE TEAM _____

- This supplementary chart is intended for prescribing subcutaneous infusions of medication only
- For all other medication see standard All Wales Medication Administration Record
- On the front of the standard chart tick the supplementary chart section and on the inside write **'On Syringe driver—see SD chart'**
- If commencing a patient on the syringe driver for the first time, please refer to the guidelines for completing a subcutaneous infusion medication record

- **For patients in the acute sector review daily and re– prescribe daily if appropriate**
- **For community based patients (including community hospitals) review as often as possible**
- ***Infusions to be administered once only, unless the prescriber specifies they are to be continuous**

MEDICINE (approved name)	DOSE	PRESCRIBER'S SIGNATURE	DATE	TIME				DOSE OF MEDICATION ADMINISTERED (Only to be used if a dose range is prescribed)				
				START	Set up by / Checked by	STOP	Stopped by / Checked by	Med 1	Med 2	Med 3	Med 4	Med 5
Medication 1												
Medication 2		Bleep / Pharmacy										
Medication 3		Diluent (Please circle)										
Medication 4		Water for Injection Or Sodium chloride 0.9% w/v										
Medication 5												
Start date / Special instructions	Duration of infusion (please circle) 24 hrs / 12hrs / Other:.....hrs											
	* Prescriber to initial if to continue →											

MEDICINE (approved name)	DOSE	PRESCRIBER'S SIGNATURE	DATE	TIME				DOSE OF MEDICATION ADMINISTERED (Only to be used if a dose range is prescribed)				
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Start date / Special instructions	Duration of infusion (please circle) 24 hrs / 12hrs / Other:.....hrs											
	* Prescriber to initial if to continue →											

CONTINUOUS SUBCUTANEOUS INFUSION MEDICATION ADMINISTRATION RECORD

CONTINUOUS SUBCUTANEOUS INFUSION MEDICATION ADMINISTRATION RECORD

PATIENT'S NAME …………………………..   HEALTH RECORD NUMBER ………………………………

***INFUSIONS TO BE ADMINISTERED ONCE ONLY, UNLESS THE PRESCRIBER SPECIFIES THEY ARE TO BE CONTINUOUS**

MEDICINE (approved name)		DOSE	PRESCRIBER'S SIGNATURE	DATE	TIME				DOSE OF MEDICATION ADMINISTERED (Only to be used if a dose range is prescribed)				
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			Pharmacy										
Medication 3			Diluent (Please circle)										
Medication 4			Water for Injection										
			Or										
Medication 5			Sodium chloride 0.9% w/v										
Start date	Special instructions	Duration of infusion (please circle)											
		24 hrs / 12hrs / Other:…….hrs											
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