First Name: Self-populated
Last Name: Self-populated
Date of Birth: Self-populated
NHS Number: Self-populated
Patient's GP practice: Self-populated
Patient's GP practice Tel Self-populated ('in hours')

Palliative Care
Patient Specific Direction
(Authority to Administer)
As Required Prescription Sheet

Primary care
This form should be printed to accompany the 'just in case' medication prescription but it should not be completed in advance. This form should only be completed if treatment is likely to commence with the next week and treatment must be reviewed at least two weekly.

	DATE dd/mm/yy	DOSE Write or tick required dose (words and figures)	FREQUENCY (up to every 'x' hours)	MAXIMUM DOSE in 24 Hours (mg) (excluding syringe driver)	ROUTE	Doctor REVIEW DATE dd/mm/yy	Doctor REVIEW DATE dd/mm/yy	Doctor's Signature NAME (capitals) GMC number
Pain: Administer only if symptom present – breakthrough dose is 1/6 of 24 hour dose								
Morphine injection					Subcut			
Nausea/Vomiting: Administer only if symptom present								
Levomepromazine (Nozinan) injection		6.25mg 12.5mg			Subcut			
Restlessness/Agitation: Administer only if symptom present								
Midazolam injection		2.5mg 5mg			Subcut			
Respiratory Tract Secretions: Administer only if symptom present								
Hyoscine butylbromide injection		20mg			Subcut			
Diluent								
Water for injection					Subcut			
Other Medications: Administer only if symptom present								

For further advice on medication
Shropdoc Professional Line - Tel 01743 454903 ('out of hours') or 01743 454900 ('in hours')
Severn Hospice – 01952 221350/01743 236565, and in the appendix of the Shropshire EOL Care plan which can be viewed or downloaded from http://www.severnhospice.org.uk/for-healthcare-professionals/gp-info-hub/eol-care-plan