First Name Given Name Last Name Surname Date of Birth Date of Birth NHS Number NHS Number	ALLERGIES/ADVERSE REACTIONS

PATIENT SPECIFIC DIRECTION AUTHORITY TO ADMINISTER

AS REQUIRED MEDICINES (PRN) v05.2024

OXYCODONE INJECTION

ADVICE TO PRESCRIBERS: This form (both pages 1&2) should be printed to accompany the 'just in case' (JIC) medication prescription and is valid for 3 months from first completion.
BEST PRACTICE IS TO PRESCRIBE A SPECIFIC DOSE, other than for pain and breathlessness.
Use the 2nd box on page 1 for continued PRN prescribing and in the event of a dose change. Ensure previously prescribed doses are crossed off before re-prescribing to avoid errors.

ADVICE TO NURSES: ADMINISTER ONLY IF SYMPTOMS PRESENT.

- If more than 4 weeks has elapsed from date prescribed (see below) the community nurse will contact the surgery, hospice NMP or out of hours service to discuss the prescribed doses prior to first administration.
- **If a dose review/change has been prescribed ONLY administer this dose.**
- If a dose range is prescribed, start at lowest dose and consider increasing to next if previous 2 dose administrations have been ineffective to manage symptoms.
- If 3 doses administered in 24 hours have been ineffective in managing symptoms please contact a prescriber, or specialist palliative care, or out of hours service for advice and support.
- If two or more doses have been needed over 24 hours consider starting a CSCI

If continued PRN prescribing is required onto another form the NURSE should contact a prescriber for a new form and cross through the old form to ensure there is no confusion

DOCTOR/NMP SECTION				**NURSE ADMINISTRATION SECTION**															
DRUG **OXYCODONE injection**			**Dose** 1.25mg ☐ 2.5mg ☐	Date															
Indication	**Frequency**	**Max in 24hrs**		Time															
PAIN BREATHLESSNESS	UP TO 1-2 hourly **if required**	7.5mg	**Subcut**	Dose															
Signature Name	Reg No		Date	Given by															
DRUG **OXYCODONE Injection** FOR DOSES ABOVE 2.5mg Or continued PRN prescribing			**Dose**	Date															
Indication	**Frequency**	**Max in 24hrs**		Time															
PAIN	UP TO 1-2 hourly **if required**		**Subcut**	Dose															
Signature Name	Reg No		Date	Given by															

First Name Given Name Last Name Surname Date of Birth Date of Birth NHS Number NHS Number	ALLERGIES/ADVERSE REACTIONS

Severn Hospice here and at home

NHS

PATIENT SPECIFIC DIRECTION AUTHORITY TO ADMINISTER

AS REQUIRED MEDICINES (PRN)

DOCTOR/ NMP SECTION				NURSE ADMINISTRATION SECTION															
DRUG **Levomepromazine injection**			**Dose** 6.25mg ☐ 12.5mg ☐ ☐	Date															
Indication	**Frequency**	**Max in 24hrs**		Time															
NAUSEA VOMTING AGITATION	UP TO 4 hourly **if required**	25mg inc pump	**Subcut**	Dose															
Signature Name			Date	Given by															
DRUG **Hyoscine Butylbromide injection**			**Dose** 20mg ☐	Date															
Indication	**Frequency**	**Max in 24hrs**		Time															
SECRETIONS COLIC	UP TO hourly **if required**	120mg inc pump	**Subcut**	Dose															
Signature Name			Date	Given by															
DRUG **Midazolam injection**			**Dose** 2.5mg ☐ 5mg ☐ ☐	Date															
Indication	**Frequency**	**Max in 24hrs**		Time															
AGITATION ANXIETY SEIZURES	UP TO 1-2 hourly **if required**	30mg Inc pump	**Subcut**	Dose															
Signature Reg No Name			Date	Given by															