

DRUG ALLERGIES & SENSITIVITIES	PLEASE CIRCLE AS APPROPRIATE:		HEALTH RECORD No: _____
	NONE KNOWN	YES	SURNAME: _____
SIGNED.....DATE.....		FIRST NAME: _____	
NAME.....		ADDRESS: _____	
Drug/Allergen:	Description of reaction		DATE OF BIRTH: _____

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

CONSULTANT/GP _____	<ul style="list-style-type: none"> 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
DATE OF ADMISSION _____	
HOSPITAL _____	
WARD _____	
DISTRICT NURSE TEAM _____	

- 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												
Medication 5		Or Sodium chloride 0.9% w/v												
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)						
				START	Set up by Checked by	STOP	Stopped by Checked by	Med 1	Med 2	Med 3	Med 4	Med 5		
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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

PATIENT'S NAME

HEALTH RECORD NUMBER

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

CONTINUOUS SUBCUTANEOUS INFUSION MEDICATION RECORD

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												
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