Sussex Community NHS
NHS Trust

Title		Name		DOB		NHS Number	
KNOWN ALLERGIES				Date the Medicine Instruction Chart Valid until:			

PRN INSTRUCTION CHART: Medicine as Needed

Chart Number: ______

GP and Practice Name and Contact Details	Specialist Palliative Care Team and Contact Details

- Clinically assess – are symptoms being effectively controlled? Check if **transdermal** patch in situ. **Instruction if in place: ______________________________**
- Ensure the PRN dose is in line with the 24 hour dose. If three or more PRN doses are needed within a 24 hour period, consider review by GP or Specialist Palliative Care Team.
- A new instruction must be written where there is a change in dose range. Put a single line through the previous instruction with your signature and date.

PAIN	**Date**	**Name of Medicine**	**Route**	**Dose Range**	**Frequency**	**Prescriber's Name**	**Prescriber's Signature** ***(as required)***	**Comments** *e.g. maximum dose*

NAUSEA VOMITING	**Date**	**Name of Medicine**	**Route**	**Dose Range**	**Frequency**	**Prescriber's Name**	**Prescriber's Signature** ***(as required)***	**Comments** *e.g. maximum dose*

ANXIETY CONFUSION RESTLESSNESS	**Date**	**Name of Medicine**	**Route**	**Dose Range**	**Frequency**	**Prescriber's Name**	**Prescriber's Signature** ***(as required)***	**Comments** *e.g. maximum dose*

RESPIRATORY SECRETIONS	**Date**	**Name of Medicine**	**Route**	**Dose Range**	**Frequency**	**Prescriber's Name**	**Prescriber's Signature** ***(as required)***	**Comments** *e.g. maximum dose*

OTHER *(Please State)*	**Date**	**Name of Medicine**	**Route**	**Dose Range**	**Frequency**	**Prescriber's Name**	**Prescriber's Signature** ***(as required)***	**Comments** *e.g. maximum dose*

DILUENT	**Date**	**Name of Diluent**	**Route**	**Volume**	**Frequency**	**Prescriber's Name**	**Prescriber's Signature** ***(as required)***	**Comments**
				As required	**As required**			

Version: FINAL Sep 11 Sussex Community NHS Trust Ratified Medicines Management Committee 22/9/11