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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PRN PRESCRIPTION CHART: Injectable Medicine as needed**  This chart is valid until indicated on the chart or 3 months if no date is recorded in the review date box. | | | | | | | | | | | | | | |
| Last Name |  | | | First  Name |  | | | | | DOB |  | | NHS number |  |
| GP & Practice name  and contact details | |  | | Palliative care team and contact details | | | |  | | Weight  (If needed) |  | | Review date |  |
| **KNOWN ALLERGIES:l**  **(Including reaction)** | | | | | | | | | | | | | | |
| 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 or  GMC/registration number | | Comments  e.g. maximum dose |
|  |  | | |  |  | |  |  | |  | |  |
|  | | | | | | | | | | | | | | |
| NAUSEA  VOMITING | | Date | Name of Medicine | | | Route | Dose range | | Frequency | Prescriber’s name | | Prescriber’s signature or GMC/registration number | | Comments  e.g. maximum dose |
|  |  | | |  |  | |  |  | |  | |  |
|  | | | | | | | | | | | | | | |
| ANXIETY  RESTLESSNESS | | Date | Name of Medicine | | | Route | Dose range | | Frequency | Prescriber’s name | | Prescriber’s signature or GMC/registration number | | Comments  e.g. maximum dose |
|  |  | | |  |  | |  |  | |  | |  |
|  | | | | | | | | | | | | | | |
| RESPIRATORY  SECRETIONS | | Date | Name of Medicine | | | Route | Dose range | | Frequency | Prescriber’s name | | Prescriber’s signature or  GMC/registration number | | Comments  e.g. maximum dose |
|  |  | | |  |  | |  |  | |  | |  |
|  | | | | | | | | | | | | | | |
| OTHER (Please state) | | Date | Name of Medicine | | | Route | Dose range | | Frequency | Prescriber’s name | | Prescriber’s signature or GMC/registration number | | Comments  e.g. maximum dose |
|  | |  |  | | |  |  | |  |  | |  | |  |
|  | | | | | | | | | | | | | | |
| DILUENT | | Date | Name of Diluent | | | Route | Volume | | Frequency | Prescriber’s name | | Prescriber’s signature or  GMC/registration number | | Comments  e.g. maximum dose |
|  |  | | |  | As required | | As required |  | |  | |  |

**If this chart is emailed without a prescriber’s signature it must be sent from the prescriber’s personal NHS email address to be valid**

**Chart confirmed from prescriber’s NHS email and printed by: Name: Signature: Registration/PIN: (*Invalid if left blank)***