|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SYRINGE DRIVER PRESCRIPTION CHART**  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:**  **(Including reaction)** | | | | | | | | | | | | | |
| Clinically assess - are symptoms being effectively controlled? Check if transdermal patch in situ. Instruction if in place ………………………………………………………………….  Medicines should be used according to symptoms. Not all medicines will necessarily need to be administered at the same time.  If symptoms are unstable review the 24 hour requirements and contact the GP or Specialist Palliative Care team for advice.  No more than three medicines should be used in the syringe driver unless this has been agreed with, & is under the supervision of, the 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  (Can also be considered for breathlessness) | | Date | | Name of Medicine | | | Route | | Dose range **over 24 hours** | | Prescriber’s name | | Prescriber’s signature or  GMC/registration number |
|  | |  | | | Sub  cutaneous | |  | |  | |  |
|  | | | | | | | | | | | | | |
| NAUSEA  VOMITING | | Date | | Name of Medicine | | | Route | | Dose range **over 24 hours** | | Prescriber’s name | | Prescriber’s signature or  GMC/registration number |
|  | |  | | | Sub  cutaneous | |  | |  | |  |
|  | | | | | | | | | | | | | |
| ANXIETY  RESTLESSNESS | | Date | | Name of Medicine | | | Route | | Dose range **over 24 hours** | | Prescriber’s name | | Prescriber’s signature or  GMC/registration number |
|  | |  | | | Sub  cutaneous | |  | |  | |  |
|  | | | | | | | | | | | | | |
| RESPIRATORY  SECRETIONS OR COLIC | | Date | | Name of Medicine | | | Route | | Dose range **over 24 hours** | | Prescriber’s name | | Prescriber’s signature or  GMC/registration number |
|  | |  | | | Sub  cutaneous | |  | |  | |  |
|  | | | | | | | | | | | | | |
| OTHER(Please state) | | Date | | Name of Medicine | | | Route | | Dose range **over 24 hours** | | Prescriber’s name | | Prescriber’s signature or  GMC/registration number |
|  | |  | |  | | | Sub  cutaneous | |  | |  | |  |
|  | | | | | | | | | | | | | |
| DILUENT | | Date | | Name of Medicine | | | Route | | Greater dilution reduces site reaction | | Prescriber’s name | | Prescriber’s signature or  GMC/registration number |
|  | |  | | | Sub  cutaneous | | Max fill 18ml for 20ml syringe  Max fill 23ml for 30ml syringe | |  | |  |

**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)***