Rau ora hospice eastern bay of plenty

SYRINGE DRIVER AUTHORITY FOR ADMINISTRATION OF MEDICATION BY A HOSPICE EBOP PALLIATIVE CARE NURSE

PATIENT	
NHI NUMBER	DATE OF BIRTH
ADDRESS	
PHONE	
GP NAME	
GP PHONE NUMBER	

Prescriber Name ..... Registration Number .....

FENTANYL PATCH *YES*	*NO*	DOSE	PATIENT ALLERGIES:

SYRINGE DRIVER AUTHORITY: Infuse the following medications subcutaneously over 24 hours

Date	Medication	Dose	Stopped/changed date + signature	Prescribers Signature
Date	**Medication may be added to syringe driver if required for new symptom**	**Dose**	**Indication/Symptom**	**Prescribers Signature**

AUTHORITY FOR MEDICATIONS IN SYRINGE DRIVER TO BE INCREASED OR DECREASED IF INDICATED

Date	Medication	Dose/Range	Indication/Symptom	Maximum 24 hour dose (PRN + Syringe Driver)	Prescribers Signature

AS NEEDED "PRN" MEDICATIONS AUTHORITY

Date	Medication	Dose/Range	Route	Frequency	Indication/Symptom/Special Instructions	Maximum 24 hour dose (PRN + Syringe Driver)	Prescribers Signature

Please email completed form to nurses@hospiceebop.org.nz

Please email/fax prescriptions to designated pharmacy.