CONTINUOUS SUBCUTANEOUS INFUSION MEDICATION ADMINISTRATION RECORD

DRUG ALLERGIES & SENSITIVITIES	PLEASE CIRCLE AS APPROPRIATE: NONE KNOWN YES SIGNED.....DATE..... NAME.....
Drug/Allergen:	Description of reaction

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

HEALTH RECORD No: _____

SURNAME: _____

FIRST NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____

CONSULTANT/GP _____

DATE OF ADMISSION _____

HOSPITAL _____

WARD _____

DISTRICT NURSE TEAM _____

- 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

- **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			1									
Medication 2		Bleep Pharmacy	2									
Medication 3		Diluent (Please circle)	3									
Medication 4		Water for Injection	4									
Medication 5		Or Sodium chloride 0.9% w/v	5									
Start date / Special instructions	Duration of infusion (please circle) 24 hrs / 12hrs / Other:.....hrs		6									
	* Prescriber to initial if to continue →		7									

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