First Name		ALLERGIES/ADVERSE REACTIONS
Last Name	Surname	
Date of Birth	Date of Birth	
NHS Number	NHS Number	

SUBCUTANEOUS AS REQUIRED MEDICINES (PRN) MORPHINE PAGE 1 (aminists) OF 3 (athor US more)





MORPHINE PAGE 1 (opioids) OF 2 (other JIC medicines)

ADVICE TO PRESCRIBERS: This form (both pages 1&2) should be printed to accompany the 'just in case' (JIC) medication prescription and is valid for 3 months from first completion. BEST PRACTICE IS TO PRESCRIBE A SPECIFIC DOSE, other than for pain and breathlessness.

Use the 2nd box on page 1 for continued PRN prescribing and in the event of a dose change. Ensure previously prescribed doses are crossed off before re-prescribing to avoid errors. ADVICE TO NURSES: ADMINISTER ONLY IF SYMPTOMS PRESENT.

- If more than 4 weeks has elapsed from date prescribed (see below) the community nurse will contact the surgery, hospice NMP or out of hours service to discuss the prescribed doses prior to first administration.
- If a dose review/change has been prescribed ONLY administer this dose.
- If a dose range is prescribed, start at lowest dose, and consider increasing to next if previous 2 dose administrations have been ineffective to manage symptoms.
- If 3 doses administered in 24 hours have been ineffective in managing symptoms please contact a prescriber, or specialist palliative care, or out of hours service for advice and support.
- If two or more doses have been needed over 24 hours consider starting a CSCI

If continued PRN prescribing is required onto another form the NURSE should contact a prescriber for a new form and cross through the old form to ensure there is no confusion

DOCTOR/NMP SECTION				NURSE ADMINISTRATION SECTION														
DRUG Morphine Sulfate injection			Dose	Date														
Indication	Frequency	Max in 24hrs	5mg	Time														
PAIN BREATHLESSNESS	UP TO 1-2 hourly if required	15mg	Subcut	Dose														
Signature Reg No Date Name			Date	Given by														
DRUG Morphine Sulfate Injection FOR DOSES ABOVE 5mg Or continued PRN prescribing		Dose	Date															
Indication	Frequency	Max in 24hrs		Time														
PAIN	UP TO 1-2 Subcut hourly if required		Dose															
Signature Reg No Date Name			Date	Given by														

First Name		ALLERGIES/ADVERSE REACTIONS
Last Name	Surname	
Date of Birth	Date of Birth	
NHS Number	NHS Number	



PATIENT SPECIFIC DIRECTION AUTHORITY TO ADMINISTER SUBCUTANEOUS AS REQUIRED MEDICINES (PRN) PAGE 2 OF 2

DOCTOR/ NMP SECTION				NURSE ADMINISTRATION SECTION														
(Dose 6.25mg	Date														
Indication	Frequency	Max in 24hrs	12.5mg	Time														
NAUSEA VOMTING AGITATION	UP TO 4 hourly if required	25mg inc pump	Subcut	Dose														
Signature Date Name			Date	Given by														
DRUG Hyoscine Butylbromide injection			Dose	Date														
Indication	Frequency	Max in 24hrs		Time														
SECRETIONS COLIC	UP TO hourly if required	120mg inc pump	Subcut	Dose														
Signature Date			Date	Given by														
DRUG Midazolam injection		Dose 2.5mg	Date															
Indication	Frequency	Max in 24hrs	5mg	Time														
AGITATION ANXIETY SEIZURES	UP TO 1-2 hourly if required	30mg inc pump	Subcut	Dose														
Signature Reg No Date		Date	Given by															
Name					1		l i		' '		l i	l i			1 ,	(l	