

AUTHORITY FOR ADMINISTRATION OF MEDICATION BY HOSPICE PALLIATIVE CARE NURSE

Surname: _____ **First Name:** _____

Date of Birth: _____ **NHI Number:** _____ **Allergies:** _____

Address: _____

Infuse the following medications subcutaneously (SC) over 24 hours:

Date	Drug	Dosage	Date Discontinued	Initials

Syringe Driver (SC) Increments:

Date	Drug	Increment increase / decrease amount	To a maximum dose of...	Frequency	Initials

Subcutaneous (SC) Boluses:

Date	Drug	Dosage	Frequency	Initials

Other medications/instructions

All Doctors using chart please complete

Name of Doctor (PRINT)	Full Signature	Initials