Tel: 07 377 4252 Fax: 07 377 4253 A/H: 0800 920 044 PO Box 950, Taupo, 3330

lake taupo
hospice
Living Every Moment

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: Anticipatory syringe driver subcutaneous infusion to be commenced if patient is unable to take oral medication or on verbal instructions from a/the prescriber.

All Prescribers using chart please complete

Name of Prescriber (PRINT)	Full Signature	Initials