



**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