

Logo

Prescription and administration record of subcutaneous medicines for **breakthrough symptoms** in primary care

- Adhere to the requirements for prescribing and administration stated in DHSSPS Use and Control of Medicines.

Special instructions / Additional notes

Allergies / Medicine sensitivities

Medicine (generic)/allergen	Type of reaction (eg. rash)	Signature / date

or

No known allergies (Please tick)

Signature: _____ Date: _____

Use addressograph - otherwise write in capitals

Surname: _____

First names: _____

Patient number: _____

DoB: _____

Address: _____

GP _____

Prescription				Administration															
Medicine				Date															
Dose	Route SC	Maximum frequency		Time															
Prescriber's signature		Start date		Batch No.															
Print name/designation		Stop date		Dose															
Special instructions/directions		Signature		Given by															
Medicine				Date															
Dose	Route SC	Maximum frequency		Time															
Prescriber's signature		Start date		Batch No.															
Print name/designation		Stop date		Dose															
Special instructions/directions		Signature		Given by															

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Medicine			Date											
Dose	Route SC	Maximum frequency	Time											
Prescriber's signature		Start date	Batch No.											
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