

As required medication (PRN) authorisation form (Essex Only)

NHS NO: 2222222222		Patient name: Mr MICKEY MOUSE		GP: MANDATORY FIELD		Transdermal patch in situ?: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
DOB: 17/07/1903	Drug allergies: e.g. Penicillin				Due date of next transdermal patch change	

Date	Medication (prescribe diluent as appropriate) (For S/C PRN doses only)	Dose		Route	Frequency	Prescriber's Registration Number	**Prescriber's name and Signature	
			This is a PRN Dose				Print Name:	*Signature:
1/1/2025	Pain Morphine Sulfate	2.5mg to 5mg	This is a PRN Dose	SC	1 hourly (max 30mg in 24 hours)	1111111	Print Name: Dr X YZ	*Signature:
1/1/2025	Nausea/ vomiting Levomepromazine	6.25mg to 12.5mg	This is a PRN Dose	SC	2 hourly (max 25mg in 24 hours)	1111111	Print Name: Dr X YZ	*Signature:
1/1/2025	Agitation/ restlessness/confusion Midazolam	2.5mg to 5mg	This is a PRN Dose	SC	1 hourly (max 30mg in 24 hours)	1111111	Print Name: Dr X YZ	*Signature:
1/1/2025	Respiratory secretions Glycopyrronium	200 micrograms	This is a PRN Dose	SC	2 hourly (max 1.2mg in 24 hours)	1111111	Print Name: Dr X YZ	*Signature:
	Other		This is a PRN Dose				Print Name:	*Signature:

Note: for NELFT Community Nurses: If you are unsure about this medication contact your senior nurse or palliative care team
 Please ensure compliance with agreed criteria where **printed prescriber name and registration number are supplied instead of a physical (wet) signature when sending via SystemOne