**COMMUNITY DRUG AUTHORISATION CHART**

**THIS CHART SUPERSEDES ALL PREVIOUS CHARTS**

**Date Issued:**

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| **Patient’s Name** |  | **STJH No:** |
| **Date of Birth** |  | **NHS No:** |
| **Origin of Chart** |  | |

**AS REQUIRED PRN SUBCUTANEOUS MEDICATION**

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| **Allergies and adverse drug reactions:** |
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| **Pain** | | | Date: |  |  |  |  |  |  |  |  |  |
| Medication: | | | Time: |  |  |  |  |  |  |  |  |  |
| Dose range: | Max frequency or  max 24hr dose: | Subcut | Dose: |  |  |  |  |  |  |  |  |  |
| Prescriber sign,  print & date: |  | | Signed: |  |  |  |  |  |  |  |  |  |

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| **Nausea / Vomitting** | | | Date: |  |  |  |  |  |  |  |  |  |
| Medication: | | | Time: |  |  |  |  |  |  |  |  |  |
| Dose range: | Max frequency or  max 24hr dose: | Subcut | Dose: |  |  |  |  |  |  |  |  |  |
| Prescriber sign,  print & date: |  | | Signed: |  |  |  |  |  |  |  |  |  |



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| **Patient’s Name** |  | **STJH No:** |
| **Date of Birth** |  | **NHS No:** |
| **Origin of Chart** |  | |

**AS REQUIRED PRN SUBCUTANEOUS MEDICATION**

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| **Agitation / Distress** | | | Date: |  |  |  |  |  |  |  |  |  |
| Medication: | | | Time: |  |  |  |  |  |  |  |  |  |
| Dose range: | Max frequency or  max 24hr dose: | Subcut | Dose: |  |  |  |  |  |  |  |  |  |
| Prescriber sign,  print & date: |  | | Signed: |  |  |  |  |  |  |  |  |  |

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| **Respiratoy tract secretions** | | | Date: |  |  |  |  |  |  |  |  |  |
| Medication: | | | Time: |  |  |  |  |  |  |  |  |  |
| Dose range: | Max frequency or  max 24hr dose: | Subcut | Dose: |  |  |  |  |  |  |  |  |  |
| Prescriber sign,  print & date: |  | | Signed: |  |  |  |  |  |  |  |  |  |



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| **Patient’s Name** |  | **STJH No:** |
| **Date of Birth** |  | **NHS No:** |
| **Origin of Chart** |  | |

**AS REQUIRED PRN SUBCUTANEOUS MEDICATION**

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| **Other – specify indication** | | | Date: |  |  |  |  |  |  |  |  |  |
| Medication: | | | Time: |  |  |  |  |  |  |  |  |  |
| Dose range: | Max frequency or  max 24hr dose: | Subcut | Dose: |  |  |  |  |  |  |  |  |  |
| Prescriber sign,  print & date: |  | | Signed: |  |  |  |  |  |  |  |  |  |

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| **Other – specify indication** | | | Date: |  |  |  |  |  |  |  |  |  |
| Medication: | | | Time: |  |  |  |  |  |  |  |  |  |
| Dose range: | Max frequency or  max 24hr dose: | Subcut | Dose: |  |  |  |  |  |  |  |  |  |
| Prescriber sign,  print & date: |  | | Signed: |  |  |  |  |  |  |  |  |  |