First Name	Given Name	ALLERGIES/ADVERSE REACTIONS
Last Name	Surname	
Date of Birth	Date of Birth	
NHS Number	NHS Number	

PATIENT SPECIFIC DIRECTION AUTHORITY TO ADMINISTER

AS REQUIRED MEDICINES (PRN) v05.2024

MORPHINE INJECTION

ADVICE TO PRESCRIBERS: This form (both pages 1&2) should be printed to accompany the 'just in case' (JIC) medication prescription and is valid for 3 months from first completion.
BEST PRACTICE IS TO PRESCRIBE A SPECIFIC DOSE, other than for pain and breathlessness.
Use the 2nd box on page 1 for continued PRN prescribing and in the event of a dose change. Ensure previously prescribed doses are crossed off before re-prescribing to avoid errors.

ADVICE TO NURSES: ADMINISTER ONLY IF SYMPTOMS PRESENT.

- If more than 4 weeks has elapsed from date prescribed (see below) the community nurse will contact the surgery, hospice NMP or out of hours service to discuss the prescribed doses prior to first administration.
- **If a dose review/change has been prescribed ONLY administer this dose.**
- If a dose range is prescribed, start at lowest dose, and consider increasing to next if previous 2 dose administrations have been ineffective to manage symptoms.
- If 3 doses administered in 24 hours have been ineffective in managing symptoms please contact a prescriber, or specialist palliative care, or out of hours service for advice and support.
- If two or more doses have been needed over 24 hours consider starting a CSCI

If continued PRN prescribing is required onto another form the NURSE should contact a prescriber for a new form and cross through the old form to ensure there is no confusion

DOCTOR/NMP SECTION				NURSE ADMINISTRATION SECTION														
DRUG **Morphine Sulfate injection**			**Dose** 2.5mg ☐ 5mg ☐	Date														
Indication	**Frequency**	**Max in 24hrs**		Time														
PAIN BREATHLESSNESS	UP TO 1-2 hourly **if required**	**15mg**	**Subcut**	Dose														
Signature Name	Reg No		Date	Given by														
DRUG **Morphine Sulfate Injection** FOR DOSES ABOVE 5mg Or continued PRN prescribing			**Dose**	Date														
Indication	**Frequency**	**Max in 24hrs**		Time														
PAIN	UP TO 1-2 hourly **if required**		**Subcut**	Dose														
Signature Name	Reg No		Date	Given by														

First Name	Given Name
Last Name	Surname
Date of Birth	Date of Birth
NHS Number	NHS Number

ALLERGIES/ADVERSE REACTIONS

Severn Hospice here and at home

NHS

PATIENT SPECIFIC DIRECTION AUTHORITY TO ADMINISTER

AS REQUIRED MEDICINES (PRN)

DOCTOR/ NMP SECTION				NURSE ADMINISTRATION SECTION														
DRUG **Levomepromazine injection**			**Dose** 6.25mg ☐ 12.5mg ☐ ☐	Date														
Indication	**Frequency**	**Max in 24hrs**		Time														
NAUSEA VOMTING AGITATION	UP TO 4 hourly **if required**	25mg inc pump	**Subcut**	Dose														
Signature Name			Date	Given by														
DRUG **Hyoscine Butylbromide injection**			**Dose** 20mg ☐	Date														
Indication	**Frequency**	**Max in 24hrs**		Time														
SECRETIONS COLIC	UP TO hourly **if required**	120mg inc pump	**Subcut**	Dose														
Signature Name			Date	Given by														
DRUG **Midazolam injection**			**Dose** 2.5mg ☐ 5mg ☐ ☐	Date														
Indication	**Frequency**	**Max in 24hrs**		Time														
AGITATION ANXIETY SEIZURES	UP TO 1-2 hourly **if required**	30mg inc pump	**Subcut**	Dose														
Signature Reg No Name			Date	Given by														