

## Subcutaneous (SC) Administration Anticipatory Prescribed Palliative Care Orders

**Medicine allergies / sensitivities:**

**Name of prescriber (PRINT):**

**Designation:**

**Registration no:**

**PRESCRIBED ORDERS FOR ADMINISTRATION \* CHART CLEARLY AND STRIKE OUT MEDICINES NOT REQUIRED\***

Medication	Dose	Route	Max. 24hr dose	Prescriber's Signature	Date
<b>FOR PAIN AND / OR SHORTNESS OF BREATH</b>					
Morphine (ampoule 10mg/1mL) <b>OR</b>		SC	6 doses		
Oxycodone (ampoule 10mg/1mL) <b>OR</b>		SC	6 doses		
Fentanyl (ampoule 100mcg/2mL) *Fentanyl is the preferred opioid if eGFR <20mL/min		SC	10 doses		
<b>FOR NAUSEA (choice dependent on aetiology, efficacy, and tolerance)</b>					
Metoclopramide (ampoule 10mg/2mL) <b>OR</b>	10mg	SC	3 doses		
Cyclizine (ampoule 50mg/mL) <b>AND/OR</b>	25-50mg	SC	150mg		
Haloperidol (ampoule 5mg/mL) <b>AND/OR</b>	0.5–1.0mg	SC	3mg		
Levomepromazine (ampoule 25mg/1mL) *Can cause sedation	2.5-5mg	SC	3 doses		
<b>FOR ANXIETY AND / OR DISTRESS</b>					
Midazolam (ampoule 15mg/3mL)	2.5-5mg	SC	6 doses		
<b>FOR TERMINAL AGITATION AND / OR TERMINAL RESTLESSNESS</b>					
Haloperidol (ampoule 5mg/mL) <b>AND/OR</b>	0.5-1.5mg	SC	3mg		
Levomepromazine (ampoule 25mg/mL)	6.25 -12.5mg	SC	4 doses		
<b>FOR DISTRESSING RETAINED RESPIRATORY SECRETIONS AT END OF LIFE OR FOR COLICKY ABDO PAIN</b>					
Hyoscine butyl bromide (ampoule 20mg/mL)	20mg	SC	6 doses		

**Prescriber: this is not a prescription.** Please additionally complete prescriptions for 5 ampoules of each of the chosen medications (with 2 repeats). Scripts to be given to patient/family or emailed directly to relevant pharmacy. For guidance prescribing these medications, please contact the Hospital Palliative Care Team (027 244 8886) or Nelson Tasman Hospice (03 546 3950). Please retain a copy of this form for your own records and email a copy to the requesting service.

**This order is valid for three months from initiation and should be reviewed regularly to ensure doses and medications remain appropriate.**

Attach Patient ID Label Here

## RECORD OF MEDICINES ADMINISTERED

### MEDICINES GIVEN

Date				
Time				
Medicine				
Strength				
Quantity				
Nurses Name				
Signature				

### MEDICINES GIVEN

Date				
Time				
Medicine				
Strength				
Quantity				
Nurses Name				
Signature				

### MEDICINES GIVEN

Date				
Time				
Medicine				
Strength				
Quantity				
Nurses Name				
Signature				

### MEDICINE DISPOSAL

Date:	Date:	Date:	Date:
Medicine:	Medicine:	Medicine:	Medicine:
Strength:	Strength:	Strength:	Strength:
Quantity:	Quantity:	Quantity:	Quantity:
Returned to pharmacy <input type="checkbox"/>	Returned to pharmacy <input type="checkbox"/>	Returned to pharmacy <input type="checkbox"/>	Returned to pharmacy <input type="checkbox"/>
Name:	Name:	Name:	Name:
Witness:	Witness:	Witness:	Witness: