

## PRN & Acute Prescribed Palliative Care Orders (APO's)

Patient Name:	NHI:
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**PLEASE DELETE DRUGS NOT REQUIRED  
PRESCRIBED ORDERS FOR ADMINISTRATION**

Drug	Dose	Indication	Dr Signature	Date	Max doses 24hrs
* Morphine (amp 10mg/1ml) IM/SC		Pain Dyspnoea			6
* Oxynorm (amp 10mg/1ml) IM/SC		Pain Dyspnoea			6
* Metocloperamide (amp 10mg/2ml) IM/SC <u>or</u>		Nausea Vomiting			3
* Cyclizine (amp 50mg/1ml) SC <u>&amp;/or</u>	25-50mg	Nausea Vomiting			3
* Haloperidol (amp 5mg/1ml) IM/SC	0.5–1.5mg	Nausea Vomiting			3
* Midazolam (amp 15mg/3ml) IM/SC <u>&amp;/or</u>		Restlessness Agitation			6
* Haloperidol (amp 5mg/1ml) IM/SC	2.5 – 5mg	Restlessness Agitation			3
* Hyoscine butylbromide (Buscopan)(amp 20mg/1ml) SC	20mg	Moist Secretions			3

If you need guidance regarding the dose, please contact the Nelson Region Hospice (03 546 3950) for advice.

Please retain a copy for own records and post original to Nelson Region Hospice, 46 Manuka St, Nelson 7010.

**DRUGS DISPENSED & STORED AT THE PATIENT'S HOUSE (R/N to complete)**

Drug				
Strength				
Quantity				
Nurses Name				

Review Date: Sept 2011	Nelson Region Hospice Trust	Approved: Dr Juliet Fleming (SMO)
Author: J Fleming (SMO)		Date: Dec 2009
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**DRUGS GIVEN**

Date				
Time				
Drug				
Strength				
Quantity				
Nurses Name				
Signature				

**DRUGS GIVEN**

Date				
Time				
Drug				
Strength				
Quantity				
Nurses Name				
Signature				

**DRUGS GIVEN**

Date				
Time				
Drug				
Strength				
Quantity				
Nurses Name				
Signature				

**DRUG DISPOSAL**

Date:	Date:	Date:	Date:
Drug:	Drug:	Drug:	Drug:
Strength:	Strength:	Strength:	Strength:
Quantity:	Quantity:	Quantity:	Quantity:
Returned to Chemist <input type="checkbox"/>	Returned to chemist <input type="checkbox"/>	Returned to chemist <input type="checkbox"/>	Returned to chemist <input type="checkbox"/>
Name:	Name:	Name:	Name:
Witness:	Witness:	Witness:	Witness: