



SYRINGE DRIVER CHECKLIST

Patient's Name:	Patient's DOB:
Inpatients:	Assess the patient and complete this record every 4 hours
•	Assess the patient and complete this record on every clinical visit

Date	Label Checked (tick)	Time syringe checked	Rate (mm)	Starting Volume (mm)	Predicted volume remaining (mm)	Actual volume remaining (mm)	Solution 1) Clear 2) Cloudy 3) Crystalised	Position	Site Condition 1) Good 2) Change ?	Battery indicator working Y or N	Initials



mm/hour in a 10 or 20 ml syringe

Directions for the Prescriber

- Write clearly in black ink using block capitals and approved names
- Delete + or -, as appropriate
- Complete and sign the authorisation

Directions for the nurse administering the medication



- Complete the nurse signature record overleaf with initials, signature and printed name
- Record administration details and sign
- Where a controlled drug (CD) is administered, a Community Nurse CD record should be completed for each CD

PATIENT'S SURNAME:	PATIENT'S FORENAME:	DATE OF BIRTH:	DRUG SENSITIVITIES			
PATIENT'S ADDRESS:	I	FIP No:				
GP NAME:	GP CONTACT DETAILS	Hospital No:				
PRESCRIPTION DATE:	VALID TO S	START UNTIL:				
+ DRUG 1	DOSE/RANGE PER 12/24 HOURS	INDICATION	INDICATION FOR ALTERATION			
+ DRUG 2	DOSE/RANGE PER 12/24 HOURS	INDICATION	INDICATION FOR ALTERATION			
+ DRUG 3	DOSE/RANGE PER 12/24 HOURS					
+ DRUG 4	DOSE/RANGE PER 12/24 HOURS	INDICATION	INDICATION FOR ALTERATION			
+ DRUG 5	DOSE/RANGE PER 12/24 HOURS	INDICATION Skin irritation/Line Patency only	LEAVE BLANK			
Route: Prescriber's No	ame and Contact Details:		Prescriber's Signature:			

PALLIATIVE CARE SYRINGE DRIVER AUTHORISATION CHART



Primary Care Trust



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PATIENT'S NAME:						-		P	ATIE	NT'S	DOE	3:								
SHEET 1	NO.																			
Authorisat	tion for as	s real	uired presc	riptio	ns	Administr	ation													
Date	Drug	- 104	ou pooc			Date														
Indication Frequency				Time																
Indication	For Alter	ation		Rou	ite	Dose														
Dose/Rang	ge		Max 24hr Dose			Route														
Prescriber	"s Name		Prescribe	r's Si	gnature	Given by														
Date	Drug					Date														
Indication				Fred	quency	Time														
Indication	For Alter	ation		Rou	ite	Dose														
Dose/Rang	ge		Max 24hr Dose			Route														
Prescriber	's Name		Prescribe	r's Si	gnature	Given by														
Date	Drug					Date														
Indication			_	Fred	quency	Time														
Indication		ation		Rou	te	Dose														
Dose/Range Max 24hr Dose				Route																
Prescriber			Prescribe	r's Si	gnature	Given by														
Date	Drug					Date														
Indication					quency	Time														
Indication		ation		Rou	ite	Dose														
Dose/Rang	_		Max 24hr Dose			Route														
Prescriber	"s Name		Prescribe	r's Si	gnature	Given by														
Date	Drug					Date														
Indication					quency	Time														
Indication		ation		Rou	ite	Dose														
Dose/Range Max 24hr Dose				Route																
Prescriber	"s Name		Prescribe	r's Si	gnature	Given by														
Nurses' Sig	gnature	Initi	als		Initials		Initials			Init	ials			Initials	S		In	itials		
Record Signature		Sign			Signature	Э	Signature		Sig	Signature			Signature			S	ignatur	e		
											5									
Print Name Print Nam		ne	Print N	iame		Pri	Print Name			Print Name				Print Name						
Nurses' Sig Record	gnature	Initi	als		Initials		Initials			Init	Initials			Initials			In	itials		
Si		Sign	nature		Signature	Э	Signat	ure		Sig	Signature			Signa	ture		S	ignatur	е	
		Prin	rint Name Print Nam		ne	Print Name		Pri	Print Name			Print Name			P	Print Name				



Date:

Time:

Diluent:

Date:

Time:

Diluent:

Drugs

Drugs

2

4 5

1

2

4 5



DATIEN : : 0 - : -			_ . _	TIO DO-	
PATIENT'S NA	AME:		PATIEN	T'S DOB:	
SHEET NO.					
Name of Docto	or or Nurse Prescriber au	uthorising prescription to	start or continue:		
Date:					
Nurse Signatui	re:				
Administration	Record				
Date:	Drugs	Dose Given	Expiry Date	Batch No.	Signature:
Time:	1 2				Nome
Diluent:	3 4 5				Name:
Date:	Drugs	Dose Given	Expiry Date	Batch No.	Signature:
Time:	1 2				Name
Diluent:	3 4 5				Name:
Date:	Drugs 1	Dose Given	Expiry Date	Batch No.	Signature:
Time:	2				Name:
Diluent:	4 5				
Date:	Drugs	Dose Given	Expiry Date	Batch No.	Signature:
Time:	2				Name:
Diluent:	4 5				- Ivanic.
Date:	Drugs	Dose Given	Expiry Date	Batch No.	Signature:
Time:	1 2 3				Name:
Diluent:	4				IVAILIC.

Expiry Date

Expiry Date

Batch No.

Batch No.

Signature:

Signature:

Name:

Name:

Dose Given

Dose Given