COMMUNITY KARDEX

For symptom control

ALL entries MUST be in CAPITAL letters and in indelible black ink.

Patients Name:
Address:
DoB:
NHS Number:
GP:

REGULAR MEDICATIONS

PRESCRIBERS SIGNATURE LIST

****This section must be completed before prescribing any drugs****

Name:				
Designation:				
Registration No:				
Signature:				

REMOTE PRINT CONFIRMATION

****This section must be completed by nurse if chart printed remotely****

Name:	Signature:	Date/Time:

ALLERGIES AND SENSITIVITIES

****This section must be completed before prescribing any drugs****

No Known Allergies	Signature:	Date:

ESSENTIAL REGULAR MEDICATIONS REQUIRING ADMINISTRATION

This section may be used for the prescribing of any essential regular medications that are NOT administered by a syringe driver. *For example transdermal patches(e.g Fentanyl, Buprenorphine, or rotigotine) and regular subcutaneous bolus injections (e.g. dexamethasone).*

Drug	Dose (in words and figures)	Frequency	Route	Date/Sign	Stop date/Sign
Drug	**Dose (in words and figures)**	**Frequency**	**Route**	**Date/Sign**	**Stop date/Sign**
Drug	**Dose (in words and figures)**	**Frequency**	**Route**	**Date/Sign**	**Stop date/Sign**
Drug	**Dose (in words and figures)**	**Frequency**	**Route**	**Date/Sign**	**Stop date/Sign**

CBC health FEDERATION

NHS North East and North Cumbria

AS REQUIRED SUBCUTANEOUS MEDICATIONS

Patients Name:
DoB:
NHS Number:

If medications / doses are stopped, cross through the relevant fields clearly to avoid error.

AS REQUIRED SUBCUTANEOUS MEDICATIONS

Drug	Indication	Route	Special Instructions
	Pain	***Subcut bolus***	

Date	Dose	Frequency	Signature	Stop Date/Sign

Drug	Indication	Route	Special Instructions
	Shortness of Breath	***Subcut bolus***	

Date	Dose	Frequency	Signature	Stop Date/Sign

Drug	Indication	Route	Special Instructions
	Agitation	***Subcut bolus***	

Date	Dose	Frequency	Signature	Stop Date/Sign

Drug	Indication	Route	Special Instructions
	Nausea/ Vomiting	***Subcut bolus***	

Date	Dose	Frequency	Signature	Stop Date/Sign

Drug	Indication	Route	Special Instructions
	Chest Secretions / Colic	***Subcut bolus***	

Date	Dose	Frequency	Signature	Stop Date/Sign

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AS REQUIRED SUBCUTANEOUS MEDICATIONS

Patients Name:
DoB:
NHS Number:

If medications / doses are stopped, cross through the relevant fields clearly to avoid error.

Drug	Indication	Route	Special Instructions
		Subcut bolus	

Date	Dose	Frequency	Signature	Stop Date/Sign

Drug	Indication	Route	Special Instructions
		Subcut bolus	

Date	Dose	Frequency	Signature	Stop Date/Sign

Drug	Indication	Route	Special Instructions
		Subcut bolus	

Date	Dose	Frequency	Signature	Stop Date/Sign

Drug	Indication	Route	Special Instructions
		Subcut bolus	

Date	Dose	Frequency	Signature	Stop Date/Sign

Drug	Indication	Route	Special Instructions
		Subcut bolus	

Date	Dose	Frequency	Signature	Stop Date/Sign

AS REQUIRED SUBCUTANEOUS MEDICATIONS

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SYRINGE DRIVER

SYRINGE DRIVER – 24 HOUR CONTINUOUS SUBCUTANEOUS INFUSION

If medications / doses are stopped, cross through the relevant fields clearly to avoid error.

Patients Name:
DOB:
NHS Number:

Driver No.	Drug (s)	Diluent	Volume to be infused	Signature	Stop/date /sign
1.			**As per protocol**		
2.			**As per protocol**		
			As per protocol		

Drug	Indication	Route	Special Instructions
	Pain/ Shortness of Breath	***Subcut***	

Date	Dose	Frequency	Signature	Stop Date/Sign
		Infusion over 24 hours		

Drug	Indication	Route	Special Instructions
	Agitation	***Subcut***	

Date	Dose	Frequency	Signature	Stop Date/Sign
		Infusion over 24 hours		

Drug	Indication	Route	Special Instructions
	Nausea/ Vomiting	***Subcut***	

Date	Dose	Frequency	Signature	Stop Date/Sign
		Infusion over 24 hours		

Drug	Indication	Route	Special Instructions
	Chest Secretions/ Colic	***Subcut***	

Date	Dose	Frequency	Signature	Stop Date/Sign
		Infusion over 24 hours		

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SYRINGE DRIVER – 24 HOUR
CONTINUOUS SUBCUTANEOUS INFUSION

If medications / doses are stopped, cross through the relevant fields clearly to avoid error.

Patients Name:
DoB:
NHS Number:

SYRINGE DRIVER

Drug	Indication	Route	Special Instructions
		Subcut	

Date	Dose	Frequency	Signature	Stop Date/Sign
		Infusion over 24 hours		

Drug	Indication	Route	Special Instructions
		Subcut	

Date	Dose	Frequency	Signature	Stop Date/Sign
		Infusion over 24 hours		

Drug	Indication	Route	Special Instructions
		Subcut	

Date	Dose	Frequency	Signature	Stop Date/Sign
		Infusion over 24 hours		

Drug	Indication	Route	Special Instructions
		Subcut	

Date	Dose	Frequency	Signature	Stop Date/Sign
		Infusion over 24 hours		

Drug	Indication	Route	Special Instructions
		Subcut	

Date	Dose	Frequency	Signature	Stop Date/Sign
		Infusion over 24 hours		

Drug	Indication	Route	Special Instructions
		Subcut	

Date	Dose	Frequency	Signature	Stop Date/Sign
		Infusion over 24 hours		