



**Queensland
Government**

**Community Subcutaneous
Medication Infusion Order
(over 24 hours)**

Facility:

Attach ADR Sticker

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: M F I

NOT A VALID
PRESCRIPTION UNLESS
IDENTIFIERS PRESENT

First Prescriber to Print Patient Name and Check Label Correct:

Allergies and Adverse Drug Reactions (ADR)

Nil known Unknown (tick appropriate box or complete details below)

Medicine (or other)	Reaction/type/date	Initials

Sign: _____ Print name: _____ Date: _____

Date:		Time (24hr):	
FROM		TO	
Prescriber name:		Name:	
Service:		Service:	
Contact details:		Contact details:	

Order is not valid unless form is authorised by prescriber.

Medication in Infusion Device (per 24 hours)

Medicine name	Dose	Route	Indication

PRN

Medicine name	Dose	Frequency	Route	Indication

Prescriber (print name): _____ Designation: _____ Signature: _____

Please forward a signed copy ASAP as the telephone order is valid for 24 hours only.
The onus is on the prescriber to ensure that this is done.

DO NOT WRITE IN THIS BINDING MARGIN

COMMUNITY SUBCUTANEOUS MEDICATION INFUSION ORDER (OVER 24 HOURS)





**Queensland
Government**

**Community Subcutaneous
Medication Infusion Order
(over 24 hours)**

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

NOT A VALID
PRESCRIPTION UNLESS
IDENTIFIERS PRESENT

Sex: M F I

Nursing Calculation and Administration Record

Date						
Time (24hr)						
Medication/ampoule conc.	Volume	Volume	Volume	Volume	Volume	Volume
/	mL	mL	mL	mL	mL	mL
/	mL	mL	mL	mL	mL	mL
/	mL	mL	mL	mL	mL	mL
/	mL	mL	mL	mL	mL	mL
/	mL	mL	mL	mL	mL	mL
/	mL	mL	mL	mL	mL	mL
/	mL	mL	mL	mL	mL	mL
Sodium chloride 0.9%	mL	mL	mL	mL	mL	mL
Total volume	mL	mL	mL	mL	mL	mL
Prepared by						
Checked by						
Rate	mL/hr	mL/hr	mL/hr	mL/hr	mL/hr	mL/hr
Total volume at commencement of infusion (after priming)	mL	mL	mL	mL	mL	mL
Date site changed						
Volume discarded at end of infusion	mL	mL	mL	mL	mL	mL
Discarded by						
Witnessed by						

DO NOT WRITE IN THIS BINDING MARGIN

Nursing Administration Record for PRN Medicines

Date	Time (24hr)	Medicine (print generic name)	Route	Dose	Given by	Comment