

SYRINGE DRIVER VARIABLE DOSE PRESCRIPTION

Name	Date of Birth	Ward / Address	Hospital No	Allergies and Drug Sensitivities
DRUG 1 (approved name)				<p align="center"><b>Special Instructions</b> (to include strategy for dose increases, and additional PRN doses, changes in patient condition)</p> <ul style="list-style-type: none"> <li>• If breakthrough pain occurs, a PRN dose of .....mg can be given every .....hours</li> <li>• If PRN dose does not control pain, increase subsequent PRN dose(s) to .....mg every .....hours to the maximum dose written on this prescription</li> <li>• If pain is controlled with Drug 1 as prescribed and no additional PRN doses have been required, repeat the <b>same</b> daily dose on the following day.</li> <li>• If pain has only been controlled with the addition of PRN doses, add total PRN doses given in previous 24 hours to the dose given in syringe driver in the previous 24hours, rounded up to the nearest 5mg but only up to maximum dose written on this prescription.</li> <li>• PRN doses may only continue to be administered as prescribed if dose does not exceed the maximum variable- dose prescription</li> <li>• If the patient/clients pain or anxiety is not controlled within the above parameters or there are concerns about sedation level or overdose, a medical review must be requested and or specialist medical advice be sought</li> </ul>
Dose per 24 hours	Route		Max dose per 24hr not to exceed.	
To be diluted in	Start date		Pharm	
Signature of Prescriber _____ Date _____				
DRUG 2 (approved name)			Pharm	
Dose per 24 hours	Route		Start date	
Signature of Prescriber _____ Date _____				
DRUG 3 (approved name)			Pharm	
Dose per 24 hours	Route		Start date	
Signature of Prescriber _____ Date _____				
Signature of Prescriber _____ Date _____				

