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| **DRUGS TO BE MIXED TOGETHER IN A SYRINGE PUMP (McKINLEY T34)****FOR CONTINUOUS SUBCUTANEOUS INFUSION OVER 24 HOURS****DILUENT IS WATER FOR INJECTION (WFI) UNLESS OTHERWISE INSTRUCTED BY PRESCRIBER** |  | **PATIENTS NAME:****NHS No:** |  | **ALLERGIES:** |

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| Month: Year:  | DATE:  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **Cautions:*** Authorisation of syringe pump drugs **in advance** is appropriate if:
* likely to be needed in a number of days;
* the patient’s deterioration is not reversible OR
* occasionally for a patient who is at high risk of a specific symptom e.g. vomiting.
* Where nursing staff do not have competency to manage syringe pumps (e.g. some nursing homes), ensure arrangements are in place before authorising syringe pump drugs **in advance** or with **dose ranges.**

Range in the syringe pump should be no more than 2 PRN doses. Seek specialist advice if considering a wider range.**Cautions re administration of syringe pump drugs authorised as a dose range:*** Start on the lowest dose in the range, unless assessment of PRN requirements indicates the need for a higher dose. Rationale for the chosen dose should be documented.
* See prescribing table for usual maximum dose of drug in 24 hours, which includes PRN and syringe pump doses.
* Max dose may be increased following specialist advice.

When adjusting syringe driver dose, it is likely that PRN dose also needs to change (opioids 1/6 24hr opioid dose). |
| \*\* If more than one syringe pump in use, indicate A or B. | *Time:* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Initials: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Syringe PumpA or B\*\*: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Drug:  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Diluent if not WFI: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Indication:  | Time: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose Range:From: To:  | Dose: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| [ ]  Start today [ ]  Start when needed Start dose: (refer to care plan) | Initials: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Prescriber Signature:  | Date:  | Syringe PumpA or B\*\*: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Drug: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Indication:  | Time: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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