PRN (WHEN REQUIRED) MEDICINE PROTOCOL

NAME OF PERSON	…… ……
DATE OF BIRTH	……
MEDICINE	…… ……
DOSE	…… ……
REASON FOR MEDICINE	…… ……
DOSAGE CRITERIA E.G. **GIVE 1 IF……. GIVE 2 IF…….**	…… ……
HOW OFTEN DOSE CAN BE REPEATED	…… ……
MAX IN 24HOURS	……
FURTHER INFO. E.G. AFTER FOOD	…… ……

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HOW THE DECISION IS REACHED ABOUT HOW AND WHEN TO GIVE	…… ……
ACTIONS TO TAKE PRIOR TO ADMINISTRATION	…… ……
ACTIONS TO TAKE POST-ADMINISTRATION **NB: Enter administration on MAR sheet**	…… ……
EXPECTED OUTCOMES	…… ……
FOLLOW UP	…… ……
CIRCUMSTANCES FOR REPORTING TO GP TICK AS APPROPRIATE	☐ Persistent need for upper level of dosage ☐ Never requesting dosage ☐ Requesting too often ☐ Side effects experienced ☐ Other (please state)
SIGNATURE	……
DATE	……
REVIEW DATE	……