PRN (WHEN REQUIRED) MEDICINES PROTOCOL

This document is protected. Click the grey box in each section to complete the form.

Name of Resident	
Date of Birth	
Medicine	
Dose	
Reason for Medicine	
Dosage criteria e.g. Give 1 if……. Give 2 if…….	
Reference to pain scale (where appropriate)? State pain scale used	
How often dose can be repeated	
Max In 24 hours	
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	

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