**PRN (WHEN REQUIRED) MEDICINES PROTOCOL**

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

|  |  |  |
| --- | --- | --- |
| Name of Person |  | |
| 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. e.g. Abbey pain scale, PAINAD scale) |  | |
| Reference to STOMP plan (where appropriate) |  | |
| How often dose can be repeated before seeking medical advice |  | |
| Max In 24 hours |  | |
| Further info. e.g. after food |  | |
| How the decision is reached about how and when to give |  | |
| Action to take before  administration |  | |
| Action to take after 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) |
|  | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | 1 | 2 | 3 | 4 | 5 | 6 |
| **Signature**  (Manager or designated staff member completing the form) |  |  |  |  |  |  |
| **Date** |  |  |  |  |  |  |
| **Review Date** |  |  |  |  |  |  |

**NOTE:** There is no expectation that a GP or pharmacist will sign the protocol. However, their input (especially that of the prescriber) may be needed in order to provide the necessary information to complete the form.