**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 administrationNB: 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.