PROGRAMMED Care

Document type:

Medication Authorisation

Attach Client Label Here

Office use only

Including ANAPHYLAXIS PROTOCOL for Injectable Medication

T 1300 364 724
F 1300 435 488

Allergies known: _____

Name of hospital / Ward / Department / Surgery: _____

Phone number: _____

Date of commencement	Drug name	Dose	Route	Frequency	Date of completion	Date / time of last dose administered by staff

ANAPHYLAXIS TREATMENT PROTOCOL for injectable medications

- Stop the bolus injection / IV fusion immediately
- Assess BP, pulse and respiration
- Call 000 and state the urgency of situation & that Adrenaline will be administered

	ADRENALINE INJECTION 1:1000 (mg/mL)	0.5ml	IM Anterolateral Thigh	Rpt every 5 min if no improvement		
	MO to specify if requesting dose greater than 0.5ml			Avoid same site for subsequent doses		

- Continue to monitor BP, pulse and respiration
- Commence CPR if required
- Stay with client until ambulance arrives

AUTHORISATION

I am the treating medical officer and authorise Programmed Care to administer the above medications. For variable dose medications, at the request of the Registered Nurse, I will provide a verbal phone order with revised written medication authority if required.

Medical Officer: _____ _____ _____

Name (please print) *Signature* *Date*

_____

Provider number