kanda

Medication Authorisation

Attach Client Label Here

Fax: 1300 435 488 | **Tel:** 1300 364 724

Allergies known:	
Name of Hospital / Ward / Department / Surgery:	
Phone number:	

Commenced (Date)	**Drug name**	**Dose**	**Route**	**Frequency**	**Completed** (Date)	**Last dose** (Date or time)
/ /					/ /	
/ /					/ /	
/ /					/ /	
/ /					/ /	
/ /					/ /	
/ /					/ /	

PICC Line / IV Medication 10ml normal saline flush: ☐ Weekly ☐ Daily

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) **MO to specify** if requesting dose greater than 0.5ml	0.5ml	IM Anterolateral Thigh	Repeat every 5 min if no improvement		
				Avoid same site for subsequent doses		

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

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AUTHORISATION

I am the treating Medical Officer and authorise Kanda to administer the above medications including the anaphylaxis treatment protocol. 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*