PO Box 325, Waikato Mail Centre, Hamilton 3240 Tel: 07 859 1260 Fax: 07 8591266

AUTHORITY FOR ADMINISTRATION OF MEDICATION BY HOSPICE PALLIATIVE CARE NURSE

Surname: ________________________________ **First Name:** __________________________

Date of Birth: ______________ **NHI Number:** _____________ **Allergies:** ___________________

Address: ____

Infuse the following medications subcutaneously (SC) over 24 hours:

Drug	Dosage	Route

Increments:

Drug	Increment increase / decrease amount	To a maximum dose of…	Frequency

Subcutaneous (SC) Boluses:

Drug	Dosage	Frequency

Other instructions: ____

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Doctor's Name: ________________________________ **Date:** ________________________

Doctor's Signature: _________________________________