Direction to administer form for administration of Hydroxocobalamin injection (DA-Vitamin B12)

Patient Name:		**MEDICINE ALLERGIES**	**Write a new DA-Vitamin B12 form if any changes are made.** **This form is valid for one year**
Patient Address:			
Date of Birth:			
NHS Number:			
(or affix patient sticker)		**MUST be completed by prescriber**	

This form below is prepopulated and can be amended. Prescribers are responsible for form content based on their clinical decision.

START DATE	MEDICINE	ROUTE	DOSE	FREQUENCY
	Hydroxocobalamin 1mg/1ml solution for injection ampoules	Intramuscularly	1mg	Every 12 weeks

Prescriber Name:		**GMC/NMP Registration number**	**MUST be completed by prescriber**	**Date and time:**	

Electronic copies do not require a wet signature

For paper copies only (if access to patient record in SystmOne is not available)

Prescriber signature: _____ Prescriber organisation: _____