Printed by: _____ Date: _____

Integrated Care System Nottingham & Nottinghamshire

Patient Name:		**MEDICINE ALLERGIES**	**Only one DA-AM form should be in use at any time. Write a new DA-AM form if any changes are made.**
Patient Address:			**Prescriber to review every 3 months if no doses administered or every month if doses administered. Document confirmation of review for clinical appropriateness in patient electronic record. (Confirmation can be verbal or via task)**
Date of Birth:			
NHS Number:			
(or affix patient sticker)		**MUST be completed by prescriber**	

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

Anticipatory / Breakthrough Medicine	**Indication**	**Route**	**Dose**	**Minimal Interval (Usually 1 hour)**	**Maximum Anticipatory / Breakthrough Medicine Dose in 24 Hours**
Prepopulated with core four anticipatory / breakthrough medicines. Blank rows for alternate/additional medicines. Electronic copies: replace or ~~strikethrough~~ unused prepopulated rows. Printed copies: ~~strikethrough~~ unused rows			**Prescriber MUST complete all boxes for lines used.** 'g' and 'mg' are acceptable abbreviations. Write micrograms and all other units in full		
Levomepromazine 25mg/ml	Nausea /Agitation	Subcutaneous	6.25mg – 12.5mg	1 hour	25mg
Midazolam 10mg/2ml	Agitation/Shortness of breath	Subcutaneous	2.5mg – 5mg	1 hour	20mg
Hyoscine butylbromide 20mg/ml	Respiratory secretions/Colic	Subcutaneous	20mg	1 hour	120mg
Include single opioid analgesic – replace or ~~strikethrough~~ if alternate opioid is indicated – see DA-AM guidance notes					
Morphine sulphate	Pain /Shortness of breath	Subcutaneous	2.5mg – 5mg	1 hour	20mg
Water for injections	For flushes as directed	Subcutaneous	as required	not applicable	not applicable

Prescribers and administrators: Please refer to DA-AM guidance notes and see page 2 for any additional patient specific instructions
Ensure all pages are printed out if printing copies of this form for patient records.

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

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: _____

Patient Name:		**MEDICINE ALLERGIES**	**Only one DA-AM form should be in use at any time. Write a new DA-AM form if any changes are made.**
Patient Address:			**Prescriber to review every 3 months if no doses administered or every month if doses administered. Document confirmation of review for clinical appropriateness in patient electronic record. (Confirmation can be verbal or via task)**
Date of Birth:			
NHS Number:			
(or affix patient sticker)		**MUST be completed by prescriber**	

Additional patient specific information

Nil information (Please replace or ~~strikethrough~~ as necessary)

Prescriber Name:		**Date and time:**	
MUST be completed by prescriber if information added		**MUST be completed by prescriber if information added**	

DA-AM guidance notes

ADMINISTRATOR:

- Dose ranges
  - Take account of the patient, previous doses, their effect and any additional information/guidance when selecting a dose to administer
  - If the patient has not previously received anticipatory / breakthrough medication for an indication, an appropriate approach is to start at the lower dose and titrate according to response
- Seek advice if
  - You need support to determine if administration of any dose is appropriate
  - You need support to determine if administration of a higher dose is appropriate
  - Two consecutive doses an hour apart do not control symptoms
  - The patient has received multiple anticipatory / breakthrough doses in 24 hours and is approaching the maximum dose in 24 hours

PRESCRIBER:

- Dose ranges (if used)
  - Must be suitable at point of writing – i.e. by directing to administer a dose range the prescriber accepts that any dose within the dose range is safe for the patient.
  - Limit to the smallest possible range. e.g. for opioid naïve patient morphine 2.5-5mg
- Medication may be required for multiple symptoms. If different doses are required for individual symptoms write medication and dose for each additional symptom on separate lines (single opioid may have multiple indications)
  - e.g. a patient established on morphine with extreme pain on movement
    - morphine for breakthrough pain/shortness of breath 7.5-10mg and morphine for pain on movement/transfer 15mg on separate rows
  - Add further instructions / clarification to the Additional patient specific information box above.
- Choice of opioid
  - Patients established on opioid – take into account any regular opioid medication and dose (e.g. oral MR, transdermal patch or subcutaneous driver)
  - Opioid naïve patients – see dosing information in links below
- Directions to administer in special groups, frail, renal impairment (eGFR ≤30ml/min/1.73m^2), hepatic impairment etc.
  - Adjust doses to account for patient condition and changes.
- For dosing information please see current Nottinghamshire APC end of life guidance and/or Palliative Care Pocketbook.