COMMUNITY MEDICATION AUTHORITY FORM

Surname: _____ Forename: _____

Date of birth: _____ NHI number: _____ Allergies: _____

Address: _____

General practitioner: _____ Weight: _____ (12 years or under only)

ALLERGIES This section must be completed before administration of any medication

Allergies/reaction to (name drug or substance)	Type of reaction

PRESCRIPTION

DRUG	DOSAGE	ROUTE	FREQUENCY

THE ABOVE MEDICATIONS MAY BE INCREASED/DECREASED TO/BY

_____

_____

_____

_____

Last given in hospice (date/time) _____

First administered in the community at (date/time) _____

In the event of anaphylactic reaction, the nurse will carry out the procedure set down in the Hospice Waikato clinical guideline on management of anaphylaxis

Doctor's name printed	Specimen signature	Date
Doctor's address		

Expiry Date:

Once completed, please email to clinical.admin@hospicewaikato.org.nz