Anticipatory Prescribing Outcome Form

Family Nursing & Home Care | Jersey Hospice Care — your care, your choice, your time | Jersey Care Federation | Primary Care Body | States of Jersey

SURNAME: _____

FORENAMES: _____

ADDRESS: _____

_____

URN: _____ DOB: _____

ADDRESSOGRAPH

File the original form in the patient notes

A copy should be faxed (fax. 720292) or e-mailed to the JHC MDT co-ordinator
CommunityTeam@jerseyhospicecare.com

ANTICPATORY MEDICATIONS	**DATE REQUESTED**	**DATE PUT IN**	**DATE REMOVED**	**JUST IN CASE (JIC) BOX** (tick)	☐ Yes ☐ No
				JIC BOX PUT IN PLACE BY (tick)	☐ Jersey Hospice ☐ Family Nursing
ANTICIPATORY MEDICATION ASSESSMENT FORM COMPLETED (tick)	☐ Yes ☐ No	If 'No' contact the team who requested the anticipatory medications to notify them of this omission			
ANY PROBLEMS GETTING MEDICINES INTO PATIENT CARE SETTING? (tick)	☐ None ☐ Medication unavailable at pharmacy ☐ Other (please state)		☐ Delay in prescribing ☐ Medication chart not completed		
REASON MEDICINES REMOVED (tick)	☐ Patient condition stabilised ☐ Change of care setting ☐ Other (please state)		☐ Patient died ☐ Admitted to Hospice IPU		

DID ANTICIPATORY MEDICATIONS PREVENT? (tick)	**Yes**	**No**	**OTHER COMMENTS**
JDOC OUT OF HOURS CALL			
ADMISSION TO HOSPITAL			
ADMISSION TO HOSPICE IPU			

MEDICATION NAME	**STRENGTH**	**QUANTITY DISPENSED**	**QUANTITY USED**	**QUANTITY RETURNED FOR DESTRUCTION**
DIAMORPHINE	**5mg**			
	10mg			
OXYCODONE	**10mg/ml**			
	20mg/2ml			
LEVOMEPROMAZINE	**25mg/ml**			
HALOPERIDOL	**5mg/ml**			
MIDAZOLAM	**10mg/2ml**			
GLYCOPYRRONIUM	**200microgram/ml**			
	600microgram/3ml			
OTHER (please state)				

Date	**Name (print)**	**Signature**	**Role**