

Consent Form for Patient or Carer Administration of Subcutaneous Medication (Palliative Care)

Name of Patient: _____

Date of Birth: _____

NHS number: _____

I _____ (*name of patient*) have requested to self-administer subcutaneous medication for the purpose of symptom relief.

OR

I _____ (*name of patient*) have requested that my carer _____ (*name of carer*) administer subcutaneous medication to me for the purpose of symptom relief.

OR

I _____ (*name of carer*) have requested to administer subcutaneous medication for the purpose of symptom relief to _____ (*name of patient*) which it has been agreed is in their best interests.

Record of training delivered

Training must be delivered in accordance with the procedure described in the information leaflet 'A Guide to Patient and Carer Administration of Subcutaneous Medication (Palliative Care)'. Complete the training record below for any supervised practice.

Name	Designation	Date	Signature	Comments

The patient/carer (*delete as appropriate*) administering subcutaneous medication fulfils the eligibility criteria:

- has undergone the necessary training and has been assessed as competent in performing the technique
- will keep an accurate record of any medication administered on the Community Palliative Care Medication Administration Chart (PM1) and remaining stock levels of medication (PM4)
- may administer an agreed maximum number of prescribed injections in any 24 hr period
- has been provided with the Information Leaflet: 'A Guide to Patient and Carer Administration of Subcutaneous Medication (Palliative Care)' which provides a guide to the procedure and information including benefits and side effects about the medication to be administered
- is happy to proceed with this delegated responsibility in the knowledge that they have 24 hr contact numbers for support and that they can relinquish the role at any time they wish
- is aware that any errors or incidents related to the patient or carer administration of subcutaneous medication (including needle stick injuries) must be reported immediately to a healthcare professional

Professionals who have considered and who are assured that all of the above criteria are fulfilled and therefore support the request for subcutaneous administration by the patient/carer are:

Name	Designation	Date agreed

Medication that may be administered by the patient / carer

Drug	Dose (mg)	Volume of injection (ml)	Indication (What the medicine is used for)	Frequency (how often)	Maximum number of doses to be given in 24 hrs	Date	Additional instructions (e.g. volume of dilution for diamorphine)	Date Stopped

Patient/Carer Training Checklist

Criteria for assessment	Confirmed (tick)	Date	Signature of Nurse to confirm competence	Comments
Person administering understands the indication for medicines and when they can be administered				
Person administering can make an assessment of symptoms				
Person administering knows how to calculate and measure the correct dose				
Person administering has demonstrated competence for administration via the s/c cannula				

I, the patient/carer (*delete as appropriate*) have undertaken training and feel competent and confident in the administration of subcutaneous medication.

Name: _____

Signature: _____

Initials: (to be used on MAR Chart) _____

Date: _____

This completed form should be retained with the patient nursing notes.