NHS
Herefordshire
Clinical Commissioning Group

PRN (WHEN REQUIRED) MEDICATION PROTOCOL

NAME OF PERSON	…… ……
DATE OF BIRTH	……
MEDICATION	…… ……
DOSE	…… ……
REASON FOR MEDICATION	…… ……
DOSAGE CRITERIA E.G. **GIVE 1 IF……. GIVE 2 IF…….**	…… ……
HOW OFTEN DOSE CAN BE REPEATED	…… ……
MAX IN 24HOURS	……
FURTHER INFO. E.G. AFTER FOOD	…… ……
HOW THE DECISION IS REACHED ABOUT HOW AND WHEN TO GIVE	…… ……

ACTIONS TO TAKE PRIOR TO ADMINISTRATION	…… ……
ACTIONS TO TAKE POST-ADMINISTRATION	…… ……
EXPECTED OUTCOME	…… ……
FOLLOW UP	…… ……
CIRCUMSTANCES FOR REPORTING TO GP TICK AS APPROPRIATE	☐ Persistent need for upper level of dosage ☐ Never requesting dosage ☐ Requesting too often ☐ Side effects experienced ☐ Other (please state)
SIGNATURE	……
DATE	……
REVIEW DATE	……

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