Oxford Health NHS
NHS Foundation Trust

DEPOT PRESCRIPTION SHEET & ADMINISTRATION RECORD

SURNAME	NHS NO:
FIRST NAMES	D.O.B.:
ADDRESS (or addressograph label)	WEIGHT Date
CMHT	
CONSULTANT PSYCHIATRIST	TEL. NO.:
CARE COORDINATOR	TEL. NO.:
IS PATIENT SUBJECT TO A SECTION/CTO: Y/N	IF PATIENT SUBJECT TO SECTION 58 IS PRESCRIPTION COVERED BY FORM T2/T3 Y/N

DETAILS OF CONCURRENT MEDICATION		
PREPARATION	DOSAGE / DIRECTIONS	DATE STARTED
OTHER INFORMATION e.g. Preferences, Delivery Instructions		
Dose change?		

THE CARD SHOULD BE FILED IN THE PATIENT'S CASE NOTES FOLDER WHEN DISCONTINUED/COMPLETED
ALSO INFORM PHARMACY OF DISCONTINUATION OF TX

ALLERGIES	SURNAME: NHS NO: FIRST NAMES: ADDRESS: D.O.B.

PRESCRIPTIONS SHOULD BE REVIEWED AND REWRITTEN AT LEAST EVERY SIX MONTHS

DEPOT /LONG ACTING I/M PRESCRIPTION

DATE	DRUG (Approved Name)	DOSE	ROUTE	FREQUENCY (weekly, fortnightly, 4 weekly, monthly)	DOCTOR'S NAME	DOCTOR'S SIGNATURE

DEPOT/ LONG ACTING I/M **ADMINISTRATION RECORD**

MONTH															
DATE															
SITE															
GIVEN BY															
MONTH															
DATE															
SITE															
GIVENBY															

DEPOT / LONG ACTING I/M PRESCRIPTION

DATE	DRUG (Approved Name)	DOSE	ROUTE	FREQUENCY (weekly, fortnightly, 4 weekly, monthly)	DOCTOR'S NAME	DOCTOR'S SIGNATURE

DEPOT/ LONG ACTING I/M **ADMINISTRATION RECORD**

MONTH															
DATE															
SITE															
GIVEN BY															
MONTH															
DATE															
SITE															
GIVEN BY															

AS REQUIRED PRESCRIPTION

DATE	DRUG (Approved Name)	DOSE	ROUTE	FREQUENCY	DOCTOR'S NAME	DOCTOR'S SIGNATURE

AS REQUIRED MEDICATION

DATE							
DOSE							
GIVEN BY							

Harlow Healthcare Tel: 0191 455 4286 163189Zp