Regal
humanity for humanity

RUN

MEDICATION ADMINISTRATION AUTHORITY FORM

PLEASE FAX TO:
(02) 9264 4556

ALL details to be completed by Attending Medical Officer
Authority becomes obsolete if any other person enters ANY detail

Name_____ **UR No**_____
SURNAME GIVEN NAME

Address_____ **DOB**

Allergies_____ ☐ **NKA**

I hereby authorise **Regal Home Health** to administer the following Medications

Medication PLEASE PRINT	Strength	Dose	Route	Frequency	Start Date	End Date

IVC insitu ☐ **Yes** **Insertion Date** _____ ☐ **No**
To be re sited on _____
☐ **Yes** **REMOVAL of IVC** **At completion of current regime**

PICC Line in situ ☐ **Yes** **Insertion Date** _____ ☐ **No**
Removal Date _____

REMOVAL of PICC Line
☐ **At completion of current regime**
☐ **Following clinical review by specialist**
☐ **By Regal Nurse** ☐ **By referrer or delegate**

_____ Medical Officer's Signature
_____ Date
_____ Please Print Name