Addressograph

Bridgewater Community Healthcare NHS
NHS Trust

GENERAL PRACTITIONER REFERRAL FORM TO THE HALTON, ST HELENS & KNOWSLEY COMMUNITY IV THERAPY SERVICE

IV THERAPY LEAD NURSE: 0777 6287606
OFFICE: 01744 626702

IV THERAPY SPECIALIST: 0777 6170758
IV THERAPY SPECIALIST: 0782 4499072

PATIENT NAME			GP NAME
NHS NUMBER			GP ADDRESS
ADDRESS			
TELEPHONE NUMBER / MOBILE NUMBER			GP TELEPHONE NUMBER
DOB	M/S/W/D		REFERRING GP
RELIGION	OCCUPATION	ETHNICITY	DIAGNOSIS
NEXT OF KIN			SIGNIFICANT MEDICAL HISTORY
ADDRESS			
TELEPHONE NUMBER			
TYPE OF DEVICE USED OPEN ENDED / CLOSED ENDED (if known)			DATE OF REVIEW BY REFERRING DOCTOR/ FOLLOW UP APPT
DATE DEVICE PLACED			
KNOWN ALLERGIES			
MRSA YES / NO			
PLEASE GIVE THE FOLLOWING DETAILS: • KNOWN COLONIZING BACTERIA • ANY ORAL MEDS • BLOOD MONITORING REQUIREMENTS & FREQUENCY			

U&E ☐
FBC ☐
LFT ☐
CRP ☐

Other (please state).....

Name of referrer..... Date .....
Print ..... Sign .....

► PLEASE ENSURE YOU HAVE DISCUSSED THIS PATIENT WITH AN IV NURSE ◄
► ONCE ACCEPTED, PLEASE FAX COMPLETED FORMS TO THE HOPT SERVICE: 01744 605951 ◄

AN INTRAVENOUS THERAPY PRESCRIPTION MUST ALSO BE COMPLETED AND FAXED TO THE IV TEAM

NHS
Halton and St Helens

COMMUNITY IV PRESCRIPTION ADVICE SHEET

Patient Details	
Name	NHS number
Address	GP
Date of Birth	GP Address
Telephone number	GP Telephone Number
Designation of Prescriber	

Only a medical/ non medical prescriber is permitted to sign this section

Date	Drug	Dose	Frequency	Diluent Please tick	✓	Further diluent Please tick	✓	Duration of treatment	Name of prescriber (PRINT) and Signature
				Water for injection		0.9% Sodium Chloride			PRINT Signature
				0.9% Sodium Chloride					
				Water for injection		0.9% Sodium Chloride			PRINT Signature
				0.9% Sodium Chloride					

Only a medical/ non medical prescriber is permitted to sign this section

Flush	Dose	Frequency	Signature of prescriber
0.9% Sodium Chloride	10ml-20ml	Pre & post every IV drug	
Hepsal (Heparin Sodium) 10iu/ml	5mls		

Administration Advice - To be completed by Community IV Team only

Signature	Print	Date

When completed please fax to IV Therapy Team 01744 605951

Please note that all drugs, diluents and flushes must be prescribed prior to discharge for the duration of treatment, and sent home with the patient.

Common Intravenous Medications used in the Community Setting

Drug	Diluent
Aciclovir	100ml bag of 0.9% Sodium Chloride /250ml bag of 0.9% Sodium Chloride
Amoxicillin	5-10ml of Water for injection
Benzylpenicillin	4-10ml water for injection to each 600mg vial
Ceftazidime	5ml -20ml Water for Injection. Doses over 2g will need further dilution with 100ml 0.9% Sodium chloride
Ceftriaxone 1g	10ml of water for injection
Ceftriaxone 2g	2g 100ml bag of 0.9% Sodium Chloride
Cefuroxime	2-6ml of water for injection
Ciprofloxacin	Already diluted
Clarithromycin	10ml water for injection and 250 ml of 0.9 Sodium Chloride
Clindamycin	50ml or 100ml bag depending upon dose
Co –amoxiclav	10ml of Water for Injection to each 600mg vial
Ertapenem	10ml of water for injection and 100ml bag of 0.9% Sodium chloride
Flucloxacillin	5-10 ml of Water for Injection/doses above 1g will need 100ml of 0.9% Sodium Chloride
Gentamicin	100ml 0.9%Sodium chloride
Imipenem	50 or 100ml bags of 0.9% sodium chloride
Meropenem	10-20ml water for injection
Metronidazole	Already diluted
Piperacillin with Tazobactum	10-20ml of water for Injection and 100ml bags of 0.9% Sodium chloride
Vancomycin	10ml water for injection to each 500mg and 250-500ml of sodium chloride depending upon dose
Iron sucrose	10 ml of 0.9% sodium chloride/ 100ml bag of 0.9% Sodium Chloride

PLEASE NOTE ALWAYS PRESCRIBE 20ml of 0.9% SODIUM CHLORIDE FOR INJECTION WITH EACH DOSE FOR EVERY PATIENT

PATIENTS WITH LONG LINES WILL NEED HEPARIN SODIUM 50iu/5ml 1 BOX PRESCRIBING AS WELL

FURTHER INFORMATION CAN BE OBTAINED FROM THE IV TEAM ON 01744 626702/07776287606

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IV Therapy Pathway For Knowsley Patients

Patient assessed as requiring IV antibiotics by clinical service

The referrer will be responsible for prescribing IV therapy and completing relevant referral documentation ensuring that all drugs diluents and flushes are provided. **Refer to Antibiotic Prescribing Formulary.** http://www.panmerseyapc.nhs.uk/formulary/documents/F14.pdf

Referral from GP, secondary care or other Health Care Professionals.
To: 01744 626702/07776287606
7am – 11pm

Microbiologist, Antibiotic Pharmacist and pharmacy support with regards to appropriate antibiotic, dose and frequency

The patient will be assessed for suitability and safety. This will include environment and drug side effects/monitoring requirements.

Accepted to the team care plan developed YES /NO

The rare cases when there are safety issues, the referrer will be signposted to alternative support

IV specialist team will determine most appropriate venous access device and provide cannulation or line placement

The IV therapy team will be able to administer IV doses between **7am-11pm**as prescribed by the referrer (excluding QDS regimes) and they will monitor the patient. All intervention by the team will be in accordance with CINS guidelines

All patient queries and problems regarding their therapy will be triaged dealt with appropriately within clinically appropriate timescales 100% of the time.

Discharge or transfer of patients to core services once treatment is completed. Throughout treatment, when appropriate, regular dialogue between the provider, the patients GP and referrer will be provided..