| **Personal Details** | | |
| --- | --- | --- |
| Name |  | |
| Date of Birth |  | |
| Restrictive Practice Approval | ☐Yes ☐No | Review date |

| **PRN Medication** | | |
| --- | --- | --- |
| Medication Name |  | |
| Prescribed by |  | |
| Information from medication label | Route e.g., oral |  |
| Time |  |
| Dose |  |
| Dosage strength |  |
| Frequency |  |
| Interval between doses |  |
| Maximum number of doses in 24 hr period |  |
| Directions e.g., relationship to other medication |  | |

| **PRN Staff Information** | |
| --- | --- |
| Date when medication was started by prescriber |  |
| Reason for use of the medication |  |
| Expected outcome of the medication |  |
| Identify staff trained in use of PRN and any potential reactions |  |
| Person responsible for observing need for medication  e.g., will the participant ask for it or will staff make the decision to offer medication |  |
| Person responsible for initiating the administration of medication |  |
| Alternatives / other course of action prior to use of PRN |  |
| Decision maker to offer medication |  |
| Person responsible to determine dosage if dosage states 1 or 2 tablets |  |

| **Description (as much detail below as possible using the following as prompts** | | |
| --- | --- | --- |
| * Behaviours * Triggers * Methods of communication | * Symptoms to look out for possible alternatives to attempt before giving medication * When to refer to prescriber | * Indicators * How you will know when to offer the medication where to record the outcome |

|  |
| --- |

| **Review Process** | |
| --- | --- |
| Review date |  |
| Is the medication meeting outcome/s listed? |  |
| Review date recorded in plans and linked to calendar for action | ☐ Support Plan ☐ Linked to calendar |
| Person responsible for undertaking review |  |
| Signature |  |