PATIENT SPECIFIC DIRECTION - Authorisation for Administration of Medication

Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

Patient Name: **NHS number:** **Date of birth:**	**Address:** **GP Practice:**

Date Authorised	NAME OF DRUG (Formulation, strength)	DOSE	ROUTE	FREQU-ENCY	Indication / Additional information	Start Date	Review Date max 12m	End Date max 12m	Prescriber Authorisation *signature not required with Smartcard authentication
									*Sign PRINT GMC/PIN no.
									*Sign PRINT GMC/PIN no.
									*Sign PRINT GMC/PIN no.

Codes for Route:
O - Oral
IM - intramuscular
SC - Subcutaneous
TD – Transdermal
ID - Intradermal
Ear - Ear drops
IV – Intravenous
Nasal - Nasal drops/spray
Eye - Eye drops
SL – Sublingual
PR - Rectal
PV – Vaginal
INH – Inhaled
Top – Topical

Allergies and sensitivities:

No known allergies ☐

1. **Prescriber to save PSD in EMIS for access by Sirona. 2. PSDs completed outside EMIS should be emailed to sirona.psd@nhs.net**