







## Adult Community IV Antibiotic Treatment: Authorisation to Administer and Administration Record Amikacin

Patient details						Allergies & Intolerances:					Indication for treatment:													
Name																								
Address																								
											Date antibiotic to start in community:													
NHS numb	er																							
DOB						No known allergies					Planned treatment length in community or end date:													
	Document nature, details and date of																							
	each reaction																							
eGFR:				Creatinine:		Date:				Weight (kg): Date:														
Medication			Dose		Frequency Rout		Route		Instructions for preparation and use										armacy heck					
								IV	Tran	sferml from 500mg/2ml amikacin vials to the 100mL sodium chloride 0.					oride 0.9	% infusio	_							
Amikacin								ba		pag. Shake well														
										<u> </u>														
Sodium chloride 0.9%				100mL				IV	Adm	ministration: Give by IV infusion over 30 minutes														
										, 9														
Sodium Chloride 0.9%									Gravity Infusion: The flush volume is the priming volume of infusion set. Withdraw															
				As S	$DP^3$	P <sup>3</sup>		_ IV		excess sodium chloride 0.9% from the bag to leave flush volume and administer at the										9				
(For Infusion Set Flush)										same rate as the infusion above.														
6 1: 611 :1 6 66/										0.9% or the PICC line with-10mL sodium chloride 0.9% before and after each administration														
Sodium Chloride 0.9%				via IV route.																				
1.Medusa - Amika	ıcin. Intraven	ous injection	. Injectable	medicines gui	de. Last upda	ited 14/06/2	21. https://	/injmed.wales.nh	s.uk/IVGu	VGuideDisplay.asp 2. SPC - Amikacin 250mg/ml Intravenous injection. Last updated 01/04/20. https://www.medicines.org.uk									cines.org.uk/e	mc/produc	ct/11189/smp			
Date &		1 /	1 /	1 /			/	1 1					1 /	1 /	1 /	1 /	1 /							
time:																								
Given by:						/				/								/						
Prescriber	must be I	2 or abo	ve, or a	suitable n	on-medic	cal presc	riber.																	
Signed:				Nam	-					Professional				Bleep/		Date:								
				(Print N	nt Name)					egistration	1		I	Telephone:										
										n	umber:													

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Authorised by: NHS @Home Pharmacy and Meds Op Group

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