COMMUNITY CELLULITIS MEDICATION AUTHORITY

Fax to 0800 867333

Surname:____________________________________Forename: ___________________

Date of Birth: __________ Phone: ______________ NHI Number: _________________

Address: ____

General Practitioner: __________________ Weight: ______________(12 years or under only)

ALLERGIES This section must be completed before administration of any medication

Allergy/Reaction To (name drug or substance)	**Type of Reaction**

PRESCRIPTION

Drug	Dosage	Route	Frequency
Cefazolin	2g	Intravenous	Daily for 2 days
Probenecid	1g	Oral	Daily for 2 days
NaCl 0.9%	10ml	Intravenous	Daily as flush

THE ABOVE MEDICATIONS MAY BE INCREASED/DECREASED TO/BY

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Last given in hospital (date/time)____

First administration in the community at (date/time) ___________________________.

In the event of an anaphylactic reaction, the nurse will carry out the procedures set down in the Community Health Management of Anaphylaxis Policy June 2004 (incorporated with WDHB Medicines Management Policy).

Doctor's Name Printed	**Specimen Signature**	**Date**
Doctors Address and MC #		

Expiry Date: ___________________________

Review Date : Jan 2008