silverchain

Medication Authority

DOB		PID number	
Gender			
Title	Surname		
Given name(s)			
Address			
	(Type or affix sticker)		

To		**From**	
Fax/email		**Title**	
Telephone		**Organisation**	
Date		**Pages**	

Dear Dr/NP ,

Silverchain has been asked to provide medication support by unregulated care staff for your client. To commence/continue services, reduce the risk of medication error, meet regulatory requirements and ensure that we can deliver a safe service to your client, please complete all relevant fields, sign and return the below medication authority. Forms can be faxed to Silverchain on **1300 601 788**.

Note: This medication authority is only valid for 12 months from the date of signing. Any change or additional medication requires a new medication authority form to be completed.

Thank you for assisting us in supporting your client to have a healthy, safe and independent life in the comfort of their home.

Name Designation Service Centre Name

Medication name		**Dose**	**Frequency**	**Route - site for application, left/right/both sides**	**Special instructions** *eg. with food or time limited medication*
Sealed Dose Administration Aid (SDAA)					
Eye/ear medication (1)					
Eye/ear medication (2)					
Topical cream					
Inhaler (1)					
Inhaler (2)					
Suppositories					
Enema (Microlax)					
Transdermal patch					
Liquid medication					
Other					

Are any of these medications chemotherapeutic agents (including cytotoxic medications)? ☐

I _____ hereby authorise Silverchain staff to administer the above medications.

Signature: _____ Provider no.: _____ Date:_____

Tel: _____ Fax: _____