## Patient specific direction (PSD) for adults with no known chronic renal impairment

|  |  |
| --- | --- |
| **Prescriber’s details (name, registration number, work address and contact details)** | **Address of patients to whom this PSD relates** |

### Treatment

I authorise the supply of 10 oseltamivir 75mg capsules to each of the patients listed below for oral administration.

The dose will be ONE capsule TWICE A DAY for 5 days

|  |  |  |
| --- | --- | --- |
| **Name** | **Date of birth** | **NHS or hospital number**  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| **Signature of prescriber** | **Date** |

### Prophylaxis

I authorise the supply of 10 oseltamivir 75mg capsules to each of the patients listed below for oral administration.

The dose will be ONE capsule ONCE A DAY for 10 days

|  |  |  |
| --- | --- | --- |
| **Name** | **Date of birth** | **NHS or hospital number**  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| **Signature of prescriber** | **Date** |

This form should be sent to the organisation that will dispense it (such as a community pharmacy or a hospital pharmacy). Where circumstances mean that it will not arrive promptly an electronic copy can be used to give advance notice of the supplies required, but the signed original must also be sent.

Cornwall and Isles of Scilly Integrated Care Board whose member practice the patients are registered with will reimburse the cost of medication and remunerate for the work involved.

## Patient specific direction (PSD) for other patients to be treated with oseltamivir

|  |  |
| --- | --- |
| **Prescriber’s details (name, registration number, work address and contact details)** | **Address of patients to whom this PSD relates** |

### Treatment

I authorise the supply of oseltamivir capsules to each of the patients listed below for oral administration:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Date of birth** | **NHS or hospital number**  | **Dose (strength and frequency)** | **Duration of treatment** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |  |
| --- | --- |
| **Signature of prescriber** | **Date** |

### Prophylaxis

I authorise the supply of oseltamivir capsules to each of the patients listed below for oral administration:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Date of birth** | **NHS or hospital number** | **Dose (strength and frequency)** | **Duration of treatment** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |  |
| --- | --- |
| **Signature of prescriber** | **Date** |

This form should be sent to the organisation that will dispense it (such as a community pharmacy or a hospital pharmacy). Where circumstances mean that it will not arrive promptly an electronic copy can be used to give advance notice of the supplies required, but the signed original must also be sent.

Cornwall and Isles of Scilly Integrated Care Board whose member practice the patients are registered with will reimburse the cost of medication and remunerate for the work involved.

## Patient specific direction (PSD) for patients to be treated with zanamivir

|  |  |
| --- | --- |
| **Prescriber’s details (name, registration number, work address and contact details)** | **Address of patients to whom this PSD relates** |

### Treatment

I authorise the supply of zanamivir inhalation powder 5mg/dose to each of the patients listed below for inhaled administration.

The dose will be TWO inhalations TWICE A DAY for 5 days

|  |  |  |
| --- | --- | --- |
| **Name** | **Date of Birth** | **NHS or hospital number** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| **Signature of prescriber** | **Date** |

### Prophylaxis

I authorise the supply of zanamivir inhalation powder 5mg/dose to each of the patients listed below for inhaled administration.

The dose will be TWO inhalations ONCE A DAY for 10 days

|  |  |  |
| --- | --- | --- |
| **Name** | **Date of Birth** | **NHS or hospital number** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| **Signature of prescriber** | **Date** |

This form should be sent to the organisation that will dispense it (such as a community pharmacy or a hospital pharmacy). Where circumstances mean that it will not arrive promptly an electronic copy can be used to give advance notice of the supplies required, but the signed original must also be sent.

Cornwall and Isles of Scilly Integrated Care Board whose member practice the patients are registered with will reimburse the cost of medication and remunerate for the work involved

## Instructions for administering capsules to patients who have difficulty swallowing or do not wish to swallow gelatine capsules

**Tamiflu® Capsules: Opening the capsules and masking the flavour**

The dose is given by opening the capsule and mixing its contents with no more than one teaspoon of a suitable sweetened food product. The bitter taste can be masked by products such as sugar water, chocolate syrup, cherry syrup, dessert toppings (like caramel or fudge sauce). The mixture should be stirred and given entirely to the patient. The mixture must be swallowed immediately after its preparation.

Source [Tamiflu Summary of Product Characteristics](https://www.medicines.org.uk/emc/product/1194#ORIGINAL)