North West Paediatric Allergy Network

INTRAMUSCULAR ADRENALINE AUTO-INJECTOR FORM

DATE OF REVIEW ______

Patient details: (sticker)

Hospital Number:

Name:

Date of Birth:

KEY ALLERGEN/S__________________

PRESCRIBER / INDICATIONS

PRESCRIBER (Emerade/Epipen/JEXT)? (circle brand) Primary ☐ Secondary ☐ Tertiary specialist ☐

Date first prescribed _____________

DEMONSTRATION Have patient/parents had a practical demonstration with auto-injector? **YES / NO**

If yes – by whom / when were they last trained?__________________________

WORST REACTION urticaria only ☐ pharyngeal symptoms ☐ bronchospasm ☐ drowsiness/LOC ☐

For resp. symptoms were they ☐ mild ☐ severe difficulty breathing

ASTHMA Does the patient have asthma requiring regular use of inhaled steroids? **YES / NO**

PREVIOUS USE Has the patient used their adrenaline auto-injector since last seen? **YES / NO**

If YES, how many reactions ___ by whom ______ details_________________

NUMBER OF PENS TOTAL _____________

Home______________ School_____________ Other _______________

COMPETENCE / POTENTIAL EFFECTIVENESS: Who was tested?: Parent ☐ Patient ☐

ACCESSIBLE Are the auto-injectors with the patient? **YES / NO**

EXPIRY Are the auto-injectors in date? **YES / NO**

DOSE Patients weight: ______ kg Dose prescribed. . . . 0.15mg ☐ 0.3mg ☐ 0.5mg ☐

COMPETENCE Do the patient/adult_____ know **how** to administer the auto-injector? **YES / NO**

If NO why:

1. no idea ☐
2. failing to remove grey cap ☐
3. not enough pressure applied to make device “click” ☐
4. not waiting 5 - 10 seconds ☐

INDICATIONS Do the patient/parents understand **when** to use the pen (respir/circ symptoms)? **YES / NO**

PATIENT HELP GROUP Have the family heard of the Anaphylaxis Campaign? **YES / NO**
Are they members? **YES / NO**

Please file a copy of this sheet in the patient’s notes
December 2016