

GCSF Discharge Communication

****THIS IS NOT A PRESCRIPTION****

Affix patient details sticker if available

NAME

DATE OF BIRTH

HOSPITAL NUMBER

NHS NUMBER

Patient's POSCU _____

Brand of GCSF Filgrastim – bespoke (manufactured in pharmacy aseptic unit) – once a day

Prefilled syringe Accofil 300microgram/0.5ml prefilled syringe – once a day

PEGFilgrastim Neulasta prefilled syringe - Stat dose 24-48hrs post chemo

Dose of GCSF: _____ microgram OD

Route: SC

GCSF to be started on : _____ **Volume if using Accofil syringe:** _____ ml

Continue GCSF for: (not applicable if PEGFilgrastim STAT dose)

Duration of GCSF: _____ days

Or

Minimum 7 days and until Neut. \geq _____ $\times 10^9/L$ for _____ consecutive occasions (post nadir)

Or

Minimum 7 days and until WCC \geq _____ $\times 10^9/L$ for _____ consecutive occasions (post nadir)

Or

Other _____

ADMINISTRATION

<input type="checkbox"/> Subcutaneous once a day	<input type="checkbox"/> PEGFilgrastim SC STAT dose
<input type="checkbox"/> The patient does not require Insuflon	Dose to be administered in local hospital. See HMR for details.
<input type="checkbox"/> The patient does require an insuflon Insuflon inserted on: _____	
Who will be administering each dose: <input type="checkbox"/> Parents / <input type="checkbox"/> CCNs / <input type="checkbox"/> Attend POSCU	
If parent – ensure parental GCSF competency form complete, and send with documentation to POSCU	

SUPPLY

Southampton have supplied patient with: _____ doses

These doses expire on: _____ (NA for prefilled syringes)

GCSF prescription for all POSCUs will be sent on the discharge summary / HMR

Southampton CCN will be sent the 'Medication Prescription Sheet' in addition

GCSF discharge information on HMR and communication sheet to be sent to:

BLOOD COUNTS

To have blood counts completed _____