**Methoxyflurane Use Form**

Methoxyflurane is a prescription-only pain-relieving medication, used by approved individuals under a standing order of the SLSNZ medical director. It is a legal requirement that appropriate records be kept. Please complete this form for every patient that receives methoxyflurane. A copy of this form and the ‘SLSNZ Incident Report Form’ must be submitted via email to SLSNZ National Lifesaving Manager: andy.kent@surflifesaving.org.nz

|  |  |
| --- | --- |
| Patient’s Name: |  |
| Patient’s Age: |  |
| Patient’s Date of Birth: |  |
| Patient’s Address: |  |
| Patient’s Phone Number: |  |

|  |  |
| --- | --- |
| Describe the patient’s injury |  |
| Describe the pain severity: (0 none, 10 worst) |  | 1 |  |  |  |  |  |  |  |  |  |

Ensure the patient has **NO contraindications**. 0 1 2 3 4 5 6 7 8 9 10

|  |  |  |
| --- | --- | --- |
| **CONTRAINDICATIONS.** | “NO” | **“YES”** **(Do not give methoxyflurane)** |
| Is the patient allergic to methoxyflurane or any other anaesthetic? |  |  |
| Does the patient (or their family) have “malignant hyperthermia”? |  |  |
| Does the patient have kidney disease? |  |  |
| Has the patient had methoxyflurane within the past 7 days? |  |  |
| Is the patient intoxicated, or unable to follow commands? |  |  |
| Is the patient haemodynamically unstable? |  |  |

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| **CONSENT** |
| Has the patient given verbal informed **consent** to methoxyflurane administration (Understanding the rare risk of adverse reactions, including allergic reactions)?  | Yes |
| No |
| Doses given (maximum 2 doses):  | Time First Dose Administered:  AM/PM | Time Second Dose Administered: AM/PM |
| **Administered by:** (name) |  |  |
| **Signature:** |  |  |
| **COMPLICATIONS** |
|  Were there any **complications** (problems)? (If yes, please describe.) | Yes |
| No |