SUBCUTANEOUS INJECTION SUPPORT PLAN

Identified need for support	Interventions
☐ Unable to self-administer injections ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Pain Management ☐ Palliative Care ☐ Other: _____ **Related for:** ☐ Hypoglycaemia ☐ Hyperglycaemia ☐ Pain **Goals** ☐ Maintain BGL range ☐ Prevent and/or manage Hypoglycaemia/ Hyperglycaemia ☐ Pain Relief **Evidenced by** ☐ Medical Directive ☐ Medical Notes ☐ Other: _____ **Diabetes Association** ☐ Yes ☐ No Membership No. & details: _____ **Palliative Care** ☐ Yes ☐ No Contact Details: _____	**Diabetes Management** ☐ Insulin Dependent ☐ Oral Medication (refer to medication chart) ☐ Diet controlled ☐ Injection (refer to medication chart) ☐ Medical Directive completed date: _____ **Blood Glucose Monitoring** ☐ Yes ☐ No / BGL frequency _____ **Participant's BGL Range (See Medical Directive)** ☐ Consult with Management if BGL ***outside of accepted range*** **Insulin Administration Order (refer to medication chart)** ☐ Yes – Notify Management of any action taken ☐ No – Consult with Management before omitting insulin or oral medication **Glucagon Administration order** ☐ Yes, refer to medication chart ☐ No **Observe for risks** **Hypoglycaemia** Sweating, dizziness, trembling, anxiety, tingling (hands, feet or tongue), blurred vision, confusion, slurred speech, unconsciousness **Hyperglycaemia** Excessive urination, excessive thirst, dry mouth, nausea/vomiting, tiredness/fatigue **Pain Management/Palliative Care (Refer to Medication Chart)** ☐ Yes – Notify Management of any action taken ☐ No – Consult with Management before omitting any medication **Subcutaneous Injection Sites** **Observe for:**

	Pain, swelling, leakage, bleeding, warmth, infection, redness, tenderness, Haematoma ☐ Site rotation and location (do not inject in bruised areas). Notify health practitioner immediately if any of these complications is observed.

Other participants specific interventions:

Risk / Response:

☐ Withdrawal
☐ Overdose
☐ Loss of consciousness

Refer to Health Practitioner or transfer to hospital if any of the above risks occur to ensure participants well-being.

Prepared by:		
Position Title:		
Signature:		Date:
Reviewed and Approved by:		
General Practitioner Name:		
General Practitioner Signature:		Date:
Health Professional Name:		
Health Professional Signature:		Date:

Agreement

By signing this Support Plan, I agree that I have been involved in the development of my plan. I agree and consent to the care and interventions of this Subcutaneous Injection Support Plan.

Participant/Representative Name:		
Participant/Representative Signature:		Date:
Company Representative Name:		
Company Representative Signature:		Date:

Communication / Copy of Support Plan	
Copy of Support Plan given to:	☐ Participant ☐ Health Professional ☐ Health Practitioner ☐ Other:

Progress Chart – Subcutaneous Injections

Date	Change to Identified Need / New Problem	Intervention	Name / Signature / Delegation

Progress Chart – Diabetes Management

Date	Change to Identified Need / New Problem	Intervention	Name / Signature / Delegation

Evaluation Chart – Subcutaneous Injections

Date	Evaluation	Name / Signature / Delegation

Evaluation Chart – Pain Management

Date	Evaluation	Name / Signature / Delegation

Evaluation Chart – Palliative Care

Date	Evaluation	Name / Signature / Delegation

Subcutaneous Injections
Medical Practitioner / Specialist / Consultant Directive

	Date:	

Diagnosis/Medical History
Specific Care Orders/Treatment Plan
Risks and Complications

Plan Review Frequency	

Informed Consent Obtained	☐ Yes ☐ No
If NO, state details:	

Authorisations

Medical Practitioner Name			
Medical Practitioner Signature		**Date**	
Client Name			
Client Signature		**Date**	

Document Control

Version No.	Issue Date	Document Owner
1	08/01/2025	Elizabeth Bradshaw
Version History		
Version No.	**Review Date**	**Revision Description**