NHS GREATER GLASGOW AND CLYDE
Women and Children's Directorate

Methotrexate for Ectopic Pregnancy

(Pre-filled Syringes)

Patient name		**HOSPITAL (please circle) PRM / RAH / QEUH Authorising Consultant……**	
CHI number		**Ward**	
Or sticky label		**Height**	
		Weight	
Date of Therapy		**Surface area (SA)**	

Hb > 100g/L	
WCC *(x 10^9/L)* >2.0	
Platelets *(x 10^9/L)* >100	

Blood result checked by: …….
(Name/signature)

Dose Number (Please circle)	Drug	SA (m^2)	Dose (Please circle)	Route	Prescribed by	Pharmacy use only
1st 2nd 3rd	**METHOTREXATE 50mg / m^2**	**≤1.2** **1.21-1.39** **1.4-1.79** **1.8-2.4** **> 2.4**	**50mg** **75mg** **80mg** **100mg** **125mg**	**IM**	……..Name ……Signature (consultant / associate specialist / registrar - please circle) Date:	Pharmacist screen …… Disp by: Checked By: Date:

N.B. Administer 125mg dose at 2 separate sites

Administered by: **Checked By:** **Date**:

Document Number	001	Supersedes	Nil
Prepared by:	Maria Tracey	Checked by:	Rosemary Anderson
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