Guidelines for the Management of Alcohol Dependence and Acute Withdrawal on Inpatient Wards

Aim of guidance:
These guidelines cover the pharmacological management of acute alcohol withdrawal in an in-patient setting. Their aim is to help clinical staff prevent withdrawal symptoms, reduce the risk of seizures, and prevent the onset of Wernicke's encephalopathy (WE).

Background Information

Alcohol withdrawal

In patients dependent on alcohol, a drop in blood-alcohol concentration may precipitate a withdrawal syndrome. This can occur as early as 6 hours after the last drink.

Withdrawal Symptoms:

- **Mild** - tremor, agitation, nausea, vomiting, disorientation and anxiety.
- **Moderate** - more pronounced symptoms and transient auditory hallucinations may also occur.
- **Severe** - marked tremor, confusion, disorientation, agitation, restlessness, fearfulness, visual and auditory hallucinations, delusions, autonomic disturbances, fast pulse, sweating, fever and dehydration. Seizures can occur 12 to 48 hours after the last drink and are more common if there is a previous history of fitting, or if the patient is on any medication (e.g. antipsychotics) that lower the seizure threshold.

Delirium Tremens (DTs)

In approximately 5% of patients withdrawal symptoms may progress to DTs, a condition characterised by delirium, auditory/visual hallucinations, coarse tremor, disorientation and reduced consciousness. DTs can be fatal and are considered a medical emergency. DTs often peak later, around 96 hours.

Wernicke's encephalopathy (WE)

WE is a neuropsychiatric complication caused by thiamine (vitamin B1) deficiency, which is characterised by a triad of symptoms:

- Confusion
- Ataxia (muscle incoordination)
- Ophthalmoplegia (paralysis of the ocular muscles)

WE often occurs in people with chronic alcohol dependence, with detox being a major risk factor. Early treatment with high dose parenteral B vitamins can reverse WE in most patients. However, if inappropriately treated or left untreated it can lead to permanent brain damage, Korsakoff's Syndrome (an irreversible condition characterised by anterograde amnesia and confabulation, with relative preservation of intellectual functions) and a 10-20% increased mortality risk. The great majority of cases of Wernicke's encephalopathy are not diagnosed until post mortem. It is therefore essential that adequate parenteral and oral thiamine replacement is employed in ALL patients.

Benzodiazepines

Benzodiazepines are the only pharmacological agents that have been shown to reduce alcohol withdrawal signs and symptoms, prevent alcohol-related seizures, and reduce Delirium Tremens. All benzodiazepines appear to be equally effective in treating withdrawal symptoms; however different benzodiazepines may suit different circumstances.

AUDIT

The Alcohol Use Disorders Identification Test (AUDIT) (appendix 1) is considered to be the most reliable screening tool for identifying alcohol misuse. The 10 item questionnaire is split into two parts; a score of ≥5 in the first 3 questions (AUDIT-C) indicates the remaining questions should be completed. An overall score of ≥8, or high scores on AUDIT-C coupled with low scores from the remaining questions, indicates probable hazardous alcohol use. High scores in questions 4-6 are indicative of alcohol dependence whereas high scores on questions 7-10 are suggestive of harmful alcohol use.

SADQ

The Severity of Alcohol Dependence Questionnaire (SADQ) (appendix 2) is a reliable tool for measuring the degree of alcohol dependence, as well as predicting the severity of potential withdrawal symptoms. The 20 question self-administered tool is scored out of a total of 60. A score of ≥20 indicates the patient is likely to require assisted alcohol withdrawal and a score of ≥30 is indicative of severe alcohol dependence.

The CIWA Scale

The Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) Scale (appendix 3) is an established tool for determining the severity of *current* withdrawal symptoms. It is best used as a way of monitoring the effect of benzodiazepines by frequent reassessment over the first day of treatment. A single CIWA Scale Measurement is less helpful, but a Score >11 suggests that a significant detoxification regimen will be required.

Guideline revised by Alexandra Moon, Clinical Services Pharmacist, 2017; approved by OH DTG May 2017
Original guideline written in 2008 by: Rachel Brown, Medicines Information Manager and Dr James Jeffs, spR, Specialist Community Addictions Service Approved by: OBMH Drug and Therapeutics Committee, December 2008

Management of Patients Suspected to Be Dependent on Alcohol

1) Assessment

Assessment of alcohol dependence should be performed by doctors and ward nurses when the patient is admitted. It is the responsibility of Community Teams choosing to admit patients to pass on information they have in regard to dependence.

Establish the following:

- Quantities (units) consumed per drinking day
- Number of days drinking in last 3 weeks
- Presence of withdrawal symptoms: currently; on non-drinking days; on waking; and in the night
- Other symptoms of Alcohol Dependence Syndrome – ICD10; Edwards and Gross
- Have they ever had a withdrawal seizure?
- Past medical history: epilepsy; peripheral neuropathy; hepatic disease; jaundice; ascites; Wernicke/ Korsakoff's
- Current Medication: epileptogenic drugs; drugs for addiction (acamprosate, disulfiram)
- Co-dependencies – e.g. on benzodiazepines or opiates
- Appropriate physical examination & breathalyser (if available)
- Investigations: to include LFTs; GGT; FBC

Assessment Tools

AUDIT *(appendix 1)*

Ask patient to complete AUDIT-C. If AUDIT-C positive (score of ≥5), ask patient to complete remaining AUDIT questions.

SADQ *(appendix 2)*

Determining the severity of dependence should combine clinical judgement (based on history and examination) and the results of the SADQ

CIWA-Ar Scale *(appendix 3)*

Regular review of the patient withdrawal and physical health allowing adjustment of dosing is important to tailor the treatment to the individual.

2) Pharmacological Management of Alcohol Detoxification

Pharmacological management should include the following:

a. **Symptom Control** – Benzodiazepines (normally chlordiazepoxide or diazepam)
b. **Thiamine/B vitamins/multivitamins**
c. **Seizure Treatment –** Benzodiazepines. Antiepileptics should not be used routinely**.**

a. <u>Symptom control</u>

The principles of dosing in detox:

1. Patients have individual needs and no guidelines can be specific to every individual.
2. Dosing should *not* be solely determined by the history; objective evidence is vital.
3. Not all patients who are misusing alcohol will have serious withdrawal symptoms.
4. Some patients may require very high doses of benzodiazepines, above the scope of these guidelines to advise on, and consideration of transfer to medical wards after discussion with psychiatry senior and medical senior may be appropriate.
5. There is *no absolute maximum dose* of benzodiazepines: tolerance can vary markedly.
6. Detox involves a delicate balance of risks. It is important to closely monitor the patient to reduce the risks from:
    a. Overdose with benzodiazepines which can cause respiratory depression and death.
    b. Under-treatment of alcohol withdrawals which can lead to Delirium Tremens, seizures and death. *The CIWA-Ar scale (appendix 3) can be used to monitor the patient's withdrawal symptoms.*

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Choice of Medication:

No liver impairment:

In the absence* of liver impairment the long acting benzodiazepines, chlordiazepoxide & diazepam are recommended as they also reduce the risk of seizures.

Chlordiazepoxide is generally preferred, but diazepam may be the option of choice in those patients requiring very high doses, due to its longer half-life.

*NB – be aware that LFTs care look completely normal in severe liver impairment

Severe liver impairment:

If there is severe liver impairment, the shorter acting benzodiazepines, oxazepam or lorazepam should be considered in order to prevent accumulation, but specialist advice should be sought. Close monitoring and frequent review will be necessary.

(Severe liver impairment can be proven or suspected i.e. significantly deranged liver function tests with clinical signs of obstructive hepatic disease or hepatic failure.)

Benzodiazepine withdrawal regimen:

The benzodiazepine regimen chosen will be determined by the severity of dependence on alcohol. Severity of alcohol dependence can be established using a combination of clinical judgement and SADQ score. The table below gives an indication of starting doses depending on SADQ score, although clinical judgement should be used to choose an exact starting dose for each individual.

SADQ Score	Starting dose of chlordiazepoxide
≥ 31 *(severe dependence)*	30 – 40mg QDS
16 – 30 *(moderate dependence)*	20 – 30mg QDS
<16 *(mild dependence)*	*Benzodiazepine not usually recommended, if withdrawal symptoms or history of severe withdrawal symptoms then start with low doses and titrate according to symptoms.*
***NB:** Older adults and patients with low body weight may require lower starting doses.*	

Prescribing a benzodiazepine withdrawal regimen:

- Chlordiazepoxide should be prescribed on the alcohol withdrawal inpatient prescription chart *(appendix 4)*.
  - The prescriber must indicate the starting dose on the prescription by crossing out the doses that are not to be used, if appropriate, and by dating and signing the chart.
  - This chart must be attached to the standard prescription chart, which must be endorsed "alcohol detoxification regimen – as per attached chart".
- If a benzodiazepine other than chlordiazepoxide is prescribed this should be prescribed on the standard prescription chart.
- PRN benzodiazepine can be prescribed for breakthrough symptoms.
  - PRN chlordiazepoxide is included in the PRN section of the alcohol withdrawal inpatient prescription chart. The prescriber should date and sign this prescription.
  - Any medication used for breakthrough symptoms should be followed by a *medical review* of the detox regimen.
  - If 3 or more PRN doses are needed in 24 hours, the reducing dose regimen should be reviewed.
- Standard detox reduces the benzodiazepine dose over 5 – 7 days, as short term treatment minimises risk of dependence. However, severely dependent patients may need to be treated for longer (up to 2 weeks). Withdrawal symptoms and PRN doses should be closely monitored and *medical review* of detox regimen if necessary.
- If there is evidence of over-sedation, the dose should be reduced or withheld and patient should have an urgent *medical review*.
- Benzodiazepines for alcohol withdrawal must not be prescribed on discharge. The use of benzodiazepines alongside drinking alcohol is dangerous.

b. Thiamine / B vitamins / multivitamins

!!Caution: **Pabrinex (parenteral thiamine) is associated, rarely, with anaphylaxis. The number of reports of anaphylaxis is 1 per 5 million pairs of IM ampoules used, i.e. low risk. Patients given IM Pabrinex should be closely monitored for 30 minutes following injection and equipment for dealing with anaphylaxis should be readily available.**

Severely alcohol-dependent patients:

- Parenteral thiamine should be prescribed for all severely alcohol-dependent patients to prevent WE. *Oral supplementation alone is not sufficient to address the deficiency because in malnourished, alcohol-dependent patients there is significantly impaired absorption of vitamins.*
- Parenteral thiamine is given in the form of intramuscular Pabrinex.
- The dose is 1 pair of ampoules daily for 3 – 5 days, depending on the severity of dependence.
- The course of parenteral thiamine should be followed by oral thiamine 100mg TDS, Vitamin B Compound Strong tablets 2 TDS and a multivitamin (1 OD).

Mild to moderately dependent patients:

Risk factors for WE:
- malnourished
- prior severe withdrawal
- current withdrawal
- past history of WE
- past history of Delirium Tremens
- frequent vomiting
- peripheral neuropathy

No risk factors → Prescribe oral supplementation:
1. thiamine 100mg TDS;
2. vitamin B Compound Strong 2 TDS
3. multivitamin 1 OD

Presence of one or more risk factors → Prescribe parenteral thiamine 1 pair of ampoules once a day for 3-5 days (depending on severity of dependence)

Then prescribe oral supplementation as above.

Thiamine / vitamins after detox

- Oral thiamine should be continued on discharge.
- There is currently no consensus as to how long treatment should continue for; clinical judgement needs to be used. Some recommend continuing for about a month following detox; however others recommend that people with ongoing chronic alcohol problems, and whose diets may remain deficient, should be given oral thiamine indefinitely. It is also not clear what the optimum dose for continuing is.
- The daily dose can be divided in order to maximise absorption, but compliance with multiple daily doses must also be considered (if compliance is considered an issue the total daily dose can be given OD)
- Continuing the prescription of Vitamin B Compound Strong (2 TDS) and a multivitamin (1 OD) post detox is also recommended and should be considered at discharge, taking into account issues with compliance.

c. Seizure Treatment

Prescribe **PRN buccal midazolam** *(Adults: 10mg, can be repeated after 10minutes if necessary)* to be used in case of seizures in patients with one of the following risk factors:

a. Very severe dependency
b. History of epilepsy or withdrawal seizures
c. Concurrent use of pro-convulsive medication

- Patients may develop seizures as the dose of benzodiazepine is tailed off. Buccal midazolam should be prescribed for withdrawal seizures (WS) and further dose reductions in the oral benzodiazepine withdrawal regimen should be delayed.
- Continuing treatment with an anticonvulsant that has been used to treat an alcohol withdrawal related seizure is not recommended.
- Phenytoin should not be offered to treat WS.

PRN midazolam is included in the "as required" section of the alcohol withdrawal inpatient prescription chart (appendix 4). This must be signed and dated by the prescriber.

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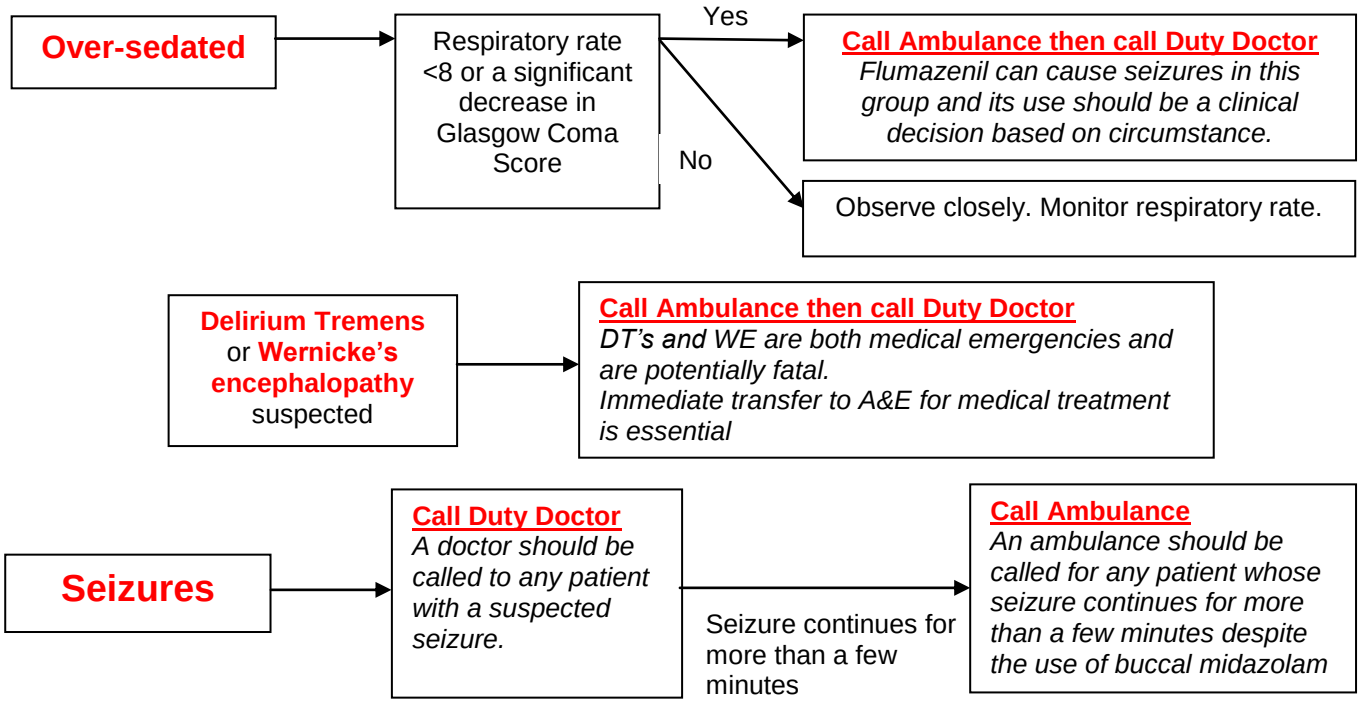
EMERGENCY SITUATIONS



For further advice on the management alcohol dependence and acute withdrawal or to refer patients for further support on discharge contact the Community Addiction Services:

Oxfordshire (Turning Point):	**Buckinghamshire (Oasis Partnership):**
• **Oxford: 01865 261690** • **Banbury: 01295 225544** • **Didcot: 01235 514360** • **Witney: 01993 849405**	• **Aylesbury: 01296 338008** • **High Wycombe: 01494 898480**

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Appendix 1: Alcohol Use Disorders Identification Test (AUDIT)

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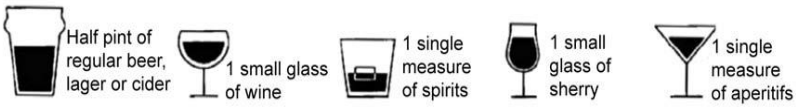
AUDIT-C

Questions	Scoring system					Your Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	*Never*	*Monthly or less*	*2-4 times per month*	*2-3 times per week*	*4+ times per week*	
How many units of alcohol do you drink on a typical day when you are drinking?	*1 - 2*	*3 - 4*	*5 - 6*	*7 - 9*	*10+*	
How often have you had 6 or more units if female, or 8 or more units if male, on a single occasion last year?	*Never*	*Less than monthly*	*Monthly*	*Weekly*	*Daily or almost daily*	

A total of ≥5 indicates increasing or higher risk drinking and is AUDIT-C positive.
Please complete remaining AUDIT questions.

Total AUDIT-C Score

This is ONE unit…



…and each of these is more than one

Remaining AUDIT questions

Questions	Scoring system					Your Score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking one you had started?	*Never*	*Less than monthly*	*Monthly*	*Weekly*	*Daily or almost daily*	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	*Never*	*Less than monthly*	*Monthly*	*Weekly*	*Daily or almost daily*	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	*Never*	*Less than monthly*	*Monthly*	*Weekly*	*Daily or almost daily*	
How often during the last year have you had a feeling of guilt or remorse after drinking?	*Never*	*Less than monthly*	*Monthly*	*Weekly*	*Daily or almost daily*	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	*Never*	*Less than monthly*	*Monthly*	*Weekly*	*Daily or almost daily*	
Have you or somebody else been injured as a result of your drinking?	*No*		*Yes, but not in the last year*		*Yes, during the last year*	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	*No*		*Yes, but not in the last year*		*Yes, during the last year*	

Scoring:
0 - 7 Lower Risk,
8 – 15 Increasing Risk,
16 - 19 Higher Risk,
20+ Possible Dependence

Total Score *(including AUDIT-C)*

Appendix 2: Severity of Alcohol Dependence Questionnaire

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NAME_____ AGE_____ No._____ DATE: _____

Please recall a typical period of heavy drinking in the last 6 months.
When was this? Month:…….. Year……..

Please answer all the following questions about your drinking by circling your most appropriate response.

During that period of heavy drinking

1. The day after drinking alcohol, I woke up feeling sweaty.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

2. The day after drinking alcohol, my hands shook first thing in the morning.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

3. The day after drinking alcohol, my whole body shook violently first thing in the morning if I didn't have a drink.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

4. The day after drinking alcohol, I woke up absolutely drenched in sweat.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

5. The day after drinking alcohol, I dread waking up in the morning.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

6. The day after drinking alcohol, I was frightened of meeting people first thing in the morning.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

7. The day after drinking alcohol, I felt at the edge of despair when I awoke.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

8. The day after drinking alcohol, I felt very frightened when I awoke.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

9. The day after drinking alcohol, I liked to have an alcoholic drink in the morning.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

10. The day after drinking alcohol, I always gulped my first few alcoholic drinks down as quickly as possible.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

11. The day after drinking alcohol, I drank more alcohol to get rid of the shakes.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

12. The day after drinking alcohol, I had a very strong craving for a drink when I awoke.
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

13. I drank more than a quarter of a bottle of spirits in a day (OR 1 bottle of wine OR 8 units of beers).
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

14. I drank more than half a bottle of spirits per day (OR 1.5 bottles of wine OR 15 units of beer).
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

15. I drank more than one bottle of spirits per day (OR 3 bottles of wine OR 30 units of beer).
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

16. I drank more than two bottles of spirits per day (OR 6 bottles of wine OR 60 units of beer)
ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

Imagine the following situation:
1. You have been **completely off drink for a few weeks**
2. You then drink **very heavily** for **two days**

How would you feel the **morning after** those two days of drinking?

17. I would start to sweat.
NOT AT ALL *SLIGHTLY* *MODERATELY* *QUITE A LOT*

18. My hands would shake.
NOT AT ALL *SLIGHTLY* *MODERATELY* *QUITE A LOT*

19. My body would shake.
NOT AT ALL *SLIGHTLY* *MODERATELY* *QUITE A LOT*

20. I would be craving for a drink.
NOT AT ALL *SLIGHTLY* *MODERATELY* *QUITE A LOT*

Score:	

Checked by: _____

NOTES ON THE USE OF THE SADQ

The Severity of Alcohol Dependence Questionnaire was developed by the Addiction Research Unit at the Maudsley Hospital. It is a measure of the severity of dependence. The AUDIT questionnaire, by contrast, is used to assess whether or not there is a problem with dependence.

The SADQ questions cover the following aspects of dependency syndrome:

- physical withdrawal symptoms
- affective withdrawal symptoms
- relief drinking
- frequency of alcohol consumption
- speed of onset of withdrawal symptoms.

Scoring

Answers to each question are rated on a four-point scale:

Almost never	-	0
Sometimes	-	1
Often	-	2
Nearly always	-	3

A score of 31 or higher indicates "severe alcohol dependence".
A score of 16 -30 indicates "moderate dependence"
A score of below 16 usually indicates only a mild physical dependency.

A chlordiazepoxide detoxification regime is usually indicated for someone who scores 16 or over.

It is essential to take account of the amount of alcohol that the patient reports drinking prior to admission as well as the result of the SADQ.

There is no correlation between the SADQ and such parameters as the MCV or GGT.

Appendix 3: The Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) Scale

Nausea & Vomiting

Ask "Do you feel sick to your stomach? Have you vomited?" Observation.

0. No nausea and no vomiting
1. Mild nausea with no vomiting
2.
3.
4. Intermittent nausea with dry heaves
5.
6.
7. Constant nausea, frequent dry heaves and vomiting

Tremor

Arms extended and fingers spread apart. Observation.

0. No tremor
1. Not visible, but can be felt fingertip to fingertip
2.
3.
4. Moderate, with patient's arms extended
5.
6.
7. Severe, even with arms not extended

Paroxysmal sweats

Observation.

0. No sweat visible
1. Barely perceptible, palms moist
2.
3.
4. Beads of sweat obvious on forehead
5.
6.
7. Drenching sweats

Anxiety

Ask "Do you feel nervous?" Observation.

0. No anxiety, at ease
1. Mildly anxious
2.
3.
4. Moderately anxious, or guarded, so anxiety is inferred
5.
6.
7. Equivalent to acute panic states seen in severe delirium or acute schizophrenic reactions.

Agitation

Observation.

0. Normal activity
1. Somewhat more than normal activity
2.
3.
4. Moderately fidgety and restless
5.
6.
7. Paces back and forth during most of the interview or constantly thrashes about

Tactile disturbances

Ask "Have you any itching, pins and needles sensations, any burning, any numbness or do you feel bugs crawling under your skin?" Observation.

0. None
1. Very mild itching, pins & needles, burning or numbness
2. Mild itching, pins & needles, burning or numbness
3. Moderate itching, pins & needles, burning or numbness
4. Moderately severe hallucinations
5. Severe hallucinations
6. Extremely severe hallucinations
7. Continuous hallucinations

Auditory disturbances

Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing you? Are you hearing things you know are not there?" Observation.

0. Not present
1. Very mild harshness or ability to frighten
2. Mild harshness or ability to frighten
3. Moderate harshness or ability to frighten
4. Moderately severe hallucinations
5. Severe hallucinations
6. Extremely severe hallucinations
7. Continuous hallucinations

Visual disturbances

Ask "Does he light appear to be too bright? Is colour different? Does it hurt your eyes? Are you seeing anything that is disturbing you? Are you seeing things you know are not there?" Observation.

0. Not present
1. Very mild sensitivity
2. Mild sensitivity
3. Moderate sensitivity
4. Moderately severe hallucinations
5. Severe hallucinations
6. Extremely severe hallucinations
7. Continuous hallucinations

Headache, fullness in head

Ask "Does your head feel different? Does it feel like there is a band around your head? Do not rate for dizziness and light-headedness. Otherwise, rate severity.

0. Not present
1. Very mild
2. Mild
3. Moderate
4. Moderately severe
5. Severe
6. Very severe
7. Extremely severe

Orientation & Clouding of sensorium

Ask "What day is this? Where are you? Who am I?"

0. Orientated and can do serial additions
1. Cannot do serial additions or is uncertain about the date
2. Disorientated for date by no more than 2 calendar days
3. Disorientated for date by more than 2 calendar days
4. Disorientated for place and/or person

Total CIWA-Ar Score _____ /67

(Max possible score is 67)

Rater's Name: _____

Date: _ _ / _ _ / _ _ _ _ Time (24hr) _ _ : _ _

Appendix 4

NHS Oxford Health NHS Foundation Trust

ALCOHOL DETOXIFICATION IN-PATIENT PRESCRIPTION CHART

Ward		**Hospital**	
Patient name		**Date of birth**	
Consultant		**Ward Dr (SHO)**	

- The chart must be attached to the standard prescription chart, which must be endorsed "alcohol detoxification regimen – as per attached chart"
- Any amendments must be clear and signed and dated by the prescriber.

Parenteral thiamine (in the form of Pabrinex) should be prescribed for all severely alcohol-dependent patients to prevent Wernicke's encephalopathy (WE). Up to five days treatment may be required. Mild to moderately-alcohol dependent patients may also require intramuscular Pabrinex if they have any risk factors for developing WE (see guideline). The length of treatment will be determined by these risk factors. Two or three days treatment may be adequate. **The prescriber must indicate the length of treatment by crossing through the days that are not required.**
Mild to moderately alcohol dependent patients *without* any risk factors for WE can be prescribed thiamine orally 100mg TDS on the main prescription chart along with vitamin B Compound Strong (2 TDS) and a multivitamin (1OD). A course of parenteral thiamine should be followed by oral thiamine 100mg TDS, Vitamin B Co Strong (2 TDS) and a multivitamin (1OD). **This should be prescribed on the regular part of the main prescription chart and consideration should be given to prescribing these medicines at discharge (see guideline).**

REGULAR MEDICATION

Drug			Date	Dr signature	Day 1	Day 2	Day 3	Day 4	Day 5
Pabrinex					Date	Date	Date	Date	Date
Dose	Frequency	Route	Pharmacy		Nurse initials	Nurse initials	Nurse initials	Nurse initials	Nurse initials
1 pair of ampoules	*Daily*	*IM*							

Chlordiazepoxide is the preferred benzodiazepine, however different benzodiazepines may suit different circumstances (see guideline). The dose of oral benzodiazepine will be determined by the severity of the dependence on alcohol (see guideline). **The Doctor must indicate the starting dose on the prescription below by crossing out the doses that are not to be used, if appropriate, and by dating the chart.**

REGULAR MEDICATION

Drug			Date	Dr signature
Chlordiazepoxide				
Dose	Frequency	Route	Pharmacy	
As below	*As below*	*PO*		

Severity of dependence		Severe	Moderate	Mild						
Day										
Date										
08.00		*40mg*	*30mg*	*20mg*	*15mg*	*10mg*	*5mg*	*5mg*		
Nurse initials										
12.00		*40mg*	*30mg*	*20mg*	*15mg*	*10mg*	*5mg*			
Nurse initials										
17/18.00		*40mg*	*30mg*	*20mg*	*15mg*	*10mg*	*5mg*			
Nurse initials										
20/22.00		*40mg*	*30mg*	*20mg*	*15mg*	*10mg*	*5mg*	*5mg*		
Nurse initials										

AS REQUIRED MEDICATION

Drug			Indication	Date	Dr signature	Date								
Chlordiazepoxide			*Breakthrough withdrawal*			Time								
Dose	Frequency	Route	Maximum	Duration	Pharmacy	Dose								
10mg	*2 – 4 hourly*	*PO*	*Total daily incl. regular = 200mg*			Sign								
Drug			Indication	Date	Dr signature	Date								
Midazolam			*Seizures*			Time								
Dose	Frequency	Route	Maximum	Duration	Pharmacy	Dose								
10mg	*10 minutes*	*Buccal*	*20mg*			Sign								