Ontario Health atHome

Pain & Symptom Management Form

Fill out or add Address Label

Name:____

Gender:________ **D.O.B.**(dd/mm/yyyy)**:** ___/____/_______

HCN: ____

Address: ____

____

____

Phone Number: ________________________________

***Contact information is critical for community IV service provision; Please Verify the Care Destination with the client.**
Additional Contact Information:____

Please Complete and Fax order form to:
OHaH 519-472-4045 or 1-855-223-2847

LINE: □ Subcutaneous □ Central Line/Port

LIST ALL Known Allergies: ____

Narcotic Prescription

□ Morphine **OR** □ HydromorphONE	□ Fentanyl	**Other Medication Order**
Concentration **(mg/ml)**: ____________________	Concentration (**mcg/ml**): ____________________	
Basal Rate **(mg/hr)**: ____________________	Basal Rate (**mcg/ hr)**: ____________________	
Bolus Dose **(mg)**: ____________________	Bolus Dose **(mcg):** ____________________	
Bolus Maximum Frequency (usual 20 or 30 minutes):________	Bolus Maximum Frequency (Usual 20 or 30 minutes):_______	If the medication is to be added to the primary narcotic bag the physician must please call pharmacy at the phone number below to ensure compatibility & dosing suitability.
Pharmacy to prepare 100 ml bags Total 100 ml. bags authorized:_______ Dispense_____bag(s) q_____days.	Pharmacy to prepare 100 ml bags Total 100 ml Bags Authorized:_______ Dispense______bag(s) q______days.	

Hydration Orders

□ Normal Saline – 0.9 % Sodium Chloride x 1 L □ Other hydration solutions: ______________________________________

Route: □ IV □ Subcutaneous

Rate:___________mL *over*___________Hours

Frequency: _________________________

Duration of In-Home Treatment:

_________ Days OR__________Doses

Special Instructions: __________________________________

Backup Emergency Analgesic Orders in Case of Infusion Interruption

Yurek to fill: □ Yes □ No

Drug:___________________________________ Route: □ S/C □ Rectal □ Other_____________

Directions:_______________________________ Quantity:____________________(for 24 hours of coverage)

Physician (PLEASE PRINT CLEARLY):

Name:	**CPSO #:**
Address:	**Cell:**
Telephone:	**Pager:**
Date:	**Signature:**

To consult with a community Pharmacist with medication questions
or if additional medications are needed please call Yurek Specialties at:
Phone: 519-680-2416, Ext. 404 or 1-888-637-3690