HOME AND COMMUNITY CARE SUPPORT SERVICES
Hamilton Niagara Haldimand Brant

SERVICES DE SOUTIEN À DOMICILE ET EN MILIEU COMMUNAUTAIRE
Hamilton Niagara Haldimand Brant

Palliative Symptom Response Order Form

Contact the Home and Communiuty Care Support Services HNHB at **1-**800-810-0000

Patient Name _____ HCN _____ VC _____ DOB _____
Address _____ City _____ Province _____ Postal Code _____
Patient Phone # _____ Contact Name _____ Contact Phone _____

NB: This order set is intended for a one-time short-term supply of medications (48 hours) if patient becomes unable to swallow. Please send separate prescription for ongoing medication orders.

Prescriber **Initials**	Medication / Directions	Mitte
For Pain and/or Dyspnea		
	Morphine_____mg subcut q_____h PRN (suggest 2 – 5 mg subcut q4 h PRN for opioid naive patient) - - - OR - - -	5 x 1mL of 10 mg/mL (LU 481)
	HYDROmorphone_____mg subcut q_____h PRN (suggest 0.5 – 1 mg subcut q4 h PRN for opioid naive patient)	☐ 5 x 1mL of 2 mg/mL OR ☐ 5 x 1mL of 10 mg/mL
For Nausea and/or Vomiting		
	Haloperidol 0.5 – 1 mg subcut q4-6 h PRN	5 x 1mL of 5 mg/mL
For Delirium and/or Agitation		
	Haloperidol 1 – 2 mg subcut q2-4 h PRN - - - OR - - -	5 x 1mL of 5 mg/mL
	Methotrimeprazine (Nozinan) 6.25 – 12.5 mg subcut q6-8 h PRN	5 x 1mL of 25 mg/mL (LU 490)
For **End Stage** Wet Respiratory Secretions		
	Scopolamine 0.4 mg subcut q4-6 h PRN - - - OR - - -	5 x 1mL of 0.4 mg/mL (LU 481)
	Glycopyrrolate 0.2 – 0.4 mg subcut q2-4 h PRN	5 x 1mL of 0.2 mg/mL (LU 481)
For Seizures		
	Midazolam 5 mg subcut STAT. Repeat q10 min PRN (max 3 doses)	3 x 1mL of 5 mg/mL (LU 495)
For Fever > 38.5 ^{O} C and/or Pain		
	Acetaminophen 650 mg per rectum q4 h PRN	4 x 650 mg suppositories
For Anxiety and/or Dyspnea		
	LORazepam 1 mg oral/sublingual q4-6 h PRN (add drops of water to dissolve)	10 x 1 mg oral tablet
For Urinary Retention		
	Foley Catheter insertion PRN (Size 14 French; or_____) Irrigate with_____mL NS PRN	

FAX completed Orders to **HCCSS** HNHB Intake & Extended Hours at 1-866-655-6402.

Note: Processing of this order form requires 24 hours ☐ Check here if order is URGENT (within 4 hours)

Signature

Referring Practitioner Name _____ CPSO/CNO# _____
Address _____
Phone (day) _____ Phone (night) _____
Signature _____ Date _____ Time _____

Version **21-001**

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