Ontario Health atHome

Pain and Symptom Management Orders

Patient Information

Surname	First Name

Home Address (including postal code)

Gender	Date of Birth (YYYY-Month-DD)

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 Ontario Health atHome: 519-472-4045 or 1-855-539-6970

Line: ◯ Subcutaneous ◯ Central Line/Port

List known allergies:

Narcotic Prescription

◯ Morphine or ◯ Hydromorphone

Concentration (mg/mL): _____ Basal rate (mg/hr): _____ Bolus dose (mg): _____

Bolus maximum frequency (usually 20 or 30 minutes): _____ minutes

Pharmacy to prepare 100ml bags: Total 100mL bags authorized: _____ Dispense _____ bag(s) q_____ days

☐ Fentanyl

Concentration (mcg/mL): _____ Basal rate (mcg/hr): _____ Bolus dose (mcg): _____

Bolus maximum frequency (usually 20 or 30 minutes): _____ minutes

Pharmacy to prepare 100mL bags. Total 100ml bags authorized: _____. Dispense _____ bag(s) q_____ days

☐ Other medication order: _____

If the medication is to be added to the primary narcotic bag, the physician must call pharmacy at the phone number below to ensure compatibility and dosing suitability

Hydration Orders

◯ Normal saline – 0.9% sodium chloride x 1L ◯ 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

Pharmacy to fill: ◯ Yes ◯ No

Drug: _____ Route: ◯ Subcutaneous ◯ Rectal ◯ Other: _____

Directions: _____ Special instructions: _____

Physician (please print clearly)

Name	CPSO #:

Address

Telephone	Cell

Date	Signature

For any additional inquiries please call Ontario Health atHome at 1-855-474-5754