

Timiskaming District Symptom Relief Kit
Symptom Relief Kit - Prescription Form

Appendix 2 - SRK
August 27, 2018

NOTE: This form must be faxed to Ontario Health atHome at 705-567-9407

Client Name: _____ HC#: _____

Date of Birth:(year/month/day)_____ Allergies: _____

Address: _____ Phone #: _____

Medications for Symptom Management
(indicate the order by initialing / struck out other meds that are not to be ordered)

MD initial	Medication CHOOSE ONE NARCOTIC	Directions	Issue:	Coverage
	Morphine 10 mg/mL subcut 1 mL vial DIN 00392588	Dose: _____ mg (____ mL) subcut Give q1 h for emergency relief of pain or dyspnea	10	LU # 481
	HYDROmorphine 2 mg/mL subcut 1 mL vial DIN 02145901	Dose: _____ mg (____ mL) subcut Give q1 h for emergency relief of pain or dyspnea	10	ODB
	HYDROmorphine 10 mg/mL subcut 1 mL vial DIN 02145928	Dose: _____ mg (____ mL) subcut Give q1 h for emergency relief of pain or dyspnea	4	ODB
MD Initial	Medication	Directions	Issue:	Coverage
	LORazepam 1 mg Tablet DIN 00655759 - p.o. DIN 02410753 - S/L	For sedation - anxiety or agitation: Give 0.5 – 2 mg q2h prn <input type="checkbox"/> by mouth or <input type="checkbox"/> Sublingual (po – crush & dissolve in water to put under tongue)	10	PO - ODB S/L - Private insurance
	Haloperidol 5 mg/mL subcut 1 mL vial DIN 00808652	For nausea and vomiting: 2 mg (0.4 mL) q6h subcut prn For Delirium/agitation: 2 mg (0.4 mL) q1h subcut prn until delirium controlled then q6h	8	ODB
	Midazolam 5mg/ml subcut 1 mL vial DIN 02242905 NOTE: Is ONLY used if all other means to manage the symptoms have failed and the patient/family is accepting of sedation. It may produce deep sedation.	For agitation or dyspnea: Give 2.5 mg (0.5mL) subcut q1h prn For seizures: Give 5 mg (1 mL) subcut q10 minutes prn x 2 doses	10	LU # 495
	Scopolamine 0.4 mg/ml DIN 00541869	For respiratory congestion or secretions: Scopolamine 0.4 mg as a single dose SC. and q4h prn SC if effective	4	LU # 481

SUPPLIES: All supplies will be ordered through Ontario Health atHome

Physician / N.P. Name PRINT: _____ CPSO: _____

→ **Physician / N.P. Signature:** _____

Date: _____

Phone#: (Daytime): _____ After hours/On-Call: _____

* PCFA (Palliative Care Facilitated Access) – Palliative Care physicians / NP with provincial designation for this coverage

☐ Delivery OR ☐ Pick-up

FAX TO: ☐ BDR Pharmacy, Kirkland Lake (705-567-3545) ☐ Findlay's Drug Store, N.L. (705-647-8227)