Narcotic Infusion Therapy Referral Form

Phone: 800-263-3877 Fax: 855-352-2555

Name:			
Address:			**Postal Code:**
Sex: ☐ **M** ☐ **F**	**Date of Birth:**		**Phone:**
HCN (mandatory):			**Version Code:**
Ordering Physician (PRINT):			
Primary Diagnosis:			
Other Diagnosis Pertinent to Care:			
Height:	Weight:	Blood Pressure:	Diabetic: ☐ Yes ☐ No
Allergies:			

IF CANCER DIAGNOSIS OR A LIFE LIMITING ILLNESS

Metastatic Spread: ☐ Yes ☐ No ☐ Describe:

Ongoing Treatment: ☐ Palliative ☐ Curative

Anticipated Prognosis: ☐ 0 <6 months ☐ 6-12 months ☐ Uncertain

MEDICATION

☐ Morphine ☐ Hydromorphone ☐ Other:

ADDED MEDS

CONCENTRATION

mg/mL (Note: The higher the concentration, the smaller the infusion volume to preserve subcutaneous routes)

ROUTE

☐ sc ☐ Other: (If IV, basal rate volume must be 0.5 mL/hr)

INFUSION RATE

Minimum mg/hr	Maximum mg/hr	Starting mg/hr

BREAKTHROUGH BOLUS DOSES

Minimum mg	Maximum mg	Starting mg

BREAKTHROUGH BOLUS INTERVAL

☐ q 15 min prn Maximum doses/hr	☐ q min prn Maximum doses/hr

RESERVOIRS

Reservoir Size ☐100 mls ☐ Other: ml	Total Quantity of Reservoirs ☐10 (ten) ☐ Other:

DISPENSE AT EACH TIME

☐ 2 (two) ☐ Other:

OTHER INFORMATION

Unless otherwise indicated, the Local Health Integration Network (LHIN) may determine frequency of treatment, arrange for teaching of patient or other reliable person and/or request assessment from other LHIN disciplines.

ORDERING PHYSICIAN/NURSE PRACTITIONER

CPSO/ CNO#:	Print Name:
Signature:	Date:

CONTACT INFORMATION FOR ORDERING PHYSICIAN

Phone:	Fax:
After Hours:	

LAB RESULTS TO BE SENT TO

Physician/Nurse Practitioner Name:	Fax:

Ontario
Central East Local Health Integration Network