Ontario
North East Local Health Integration Network
Réseau local d'intégration des services de santé du Nord-Est

ADDENDUM TO NE LHIN eREFERRAL
PALLIATIVE / END-OF-LIFE MEDICAL ORDERS

Patient's Surname:	First name(s):		
D.O.B. (DD/MM/YYYY):	Telephone: ( ) -	Health Card Number #:	Version Code:
Address:		Diagnosis:	
Allergies: ☐ No Known Drug Allergies ☐ Latex Allergy ☐ Drug Allergies (List):			

Services Requested: ☐ Nurse Practitioner Palliative Care *Sudbury, West Nipissing, Sault Ste. Marie, Timmins & District of Temiskaming only

Previous Opioid Medication needed in last 24-hour period (oral conversion to subcutaneous): _____

►	DRUG	BASAL INFUSION RATE: For optimum management, we recommend a dosage range. We apply the following auxiliary label to cassette for nursing staff: **"Please start with the lowest infusion rate & bolus indicated. May titrate basal rate up IN SMALL INCREMENTS when excessive boluses required in previous 24-hour period."**	DEFAULT CONCENTRATION (Others available upon request)
	☐ **Hydromorphone Subcutaneous**	☐ (0.1mg to 1mg/hr range): _____ **to** _____ **mg/hr** ☐ **PRN only**	1mg/mL
		☐ (0.5mg to 5mg/hr range): _____ **to** _____ **mg/hr**	5mg/mL
		☐ (1mg to 10mg/hr range): _____ **to** _____ **mg/hr**	10mg/mL
		☐ (10mg to 20mg/hr range): _____ **to** _____ **mg/hr**	20mg/mL
	☐ **Morphine Subcutaneous**	☐ (0.5mg to 5mg/hr range): _____ **to** _____ **mg/hr**	5mg/mL
		☐ (5mg to 20mg/hr range): _____ **to** _____ **mg/hr**	20mg/mL
		☐ (20mg to 40mg/hr range): _____ **to** _____ **mg/hr**	40mg/mL
	☐ **Other Subcutaneous**	Specify _____ ☐ Add 4mg of Dexamethasone to each cassette (for site irritation)	
►	**BOLUS* Subcutaneous**	_____ **mg to** _____ **mg q.30 minutes PRN (HALF OF BASAL)**	
►	**Total Quantity Authorized:** ☐ **5** ☐ **10 x 100mL Cassettes** or ☐ **Other Quantity:** _____ **To be dispensed 1 cassette no earlier than q.4 days** (considering variables of concentration and bolus frequency)		

☐ CHANGE ABOVE ORDER TO **PICC LINE Infusion** with conversion of appropriate concentration to 250mL bags
(ONLY exceptional cases when subcutaneous site is no longer an option)

ADDITIONAL MEDICATION ORDER: Drug: _____ **Concentration:**_____ **mg/mL**
Route: ☐ **Subcutaneous** ☐ **Peripheral** ☐ **Central** **Infusion Rate:** _____ **mg/hr** **Bolus:** _____ **mg/** _____ **min**
Total Quantity: _____ **x100mL** **Release: 1 cassette q.**_____ **days** (Note Stability: Ketamine: 7 days, Midazolam: 10 days).

Flush Instructions: ☐ Local Nursing Provider protocol unless otherwise specified
☐ Other (Specify): _____

Site Care: ☐ As per Best Practice Guidelines (e.g. Canadian Vascular Access Association; Registered Nurses' Association of Ontario) ☐ Other (Specify): _____
Next dressing change due (DD/MM/YYYY)**:** _____ **Note: Radiologic Report confirming PICC line placement must accompany referral**

Please note that in rural areas a 48 hour turnaround time may be required. Patients must return to primary care practitioner or local outpatient services to receive therapy or be maintained on alternate route until medication/equipment-supplies are available.
As a practitioner, I understand and agree that it is my responsibility to monitor and follow-up on blood work results to adjust the prescribed dosages and discontinue treatment when applicable.

Physician Name	CPSO#	Physician Signature	Date (DD/MM/YYYY)

Community Pharmacist: _____ Date (DD/MM/YYYY): _____

North East LHIN Offices: **Toll Free Tel: 1 800 461 2919** Website: http://healthcareathome.ca/northeast/en

☐ **KIRKLAND LAKE**	☐ **NORTH BAY**	☐ **PARRY SOUND**	☐ **SAULT STE. MARIE**	☐ **SUDBURY**	☐ **TIMMINS**
Fax: 705 567 9407	Fax: 705 474 0080	Fax: 705 773 4056	Fax: 705 949 1663	Fax: 705 522 3855	Fax: 705 360 5554