

Name: _____
Gender: _____ **D.O.B.**(dd/mm/yyyy): ____/____/____
HCN: _____
Address: _____

Phone Number: _____

Pain & Symptom Management Form

***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: South
 West LHIN 519-472-4045 or 1-855-223-2847**

LINE: Subcutaneous Central Line/Port

LIST ALL Known Allergies: _____

Narcotic Prescription

Morphine **OR** HydromorphONE

Concentration (mg/ml): _____

Basal Rate (mg/hr): _____

Bolus Dose (mg): _____

Bolus Maximum Frequency
(usual 20 or 30 minutes): _____

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

Fentanyl

Concentration (mcg/ml): _____

Basal Rate (mcg/ hr): _____

Bolus Dose (mcg): _____

Bolus Maximum Frequency
(Usual 20 or 30 minutes): _____

Pharmacy to prepare 100 ml bags
 Total 100 ml 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 please call pharmacy at the phone number below to ensure compatibility & dosing suitability.

Hydration Orders

Normal Saline – 0.9 % Sodium Chloride x 1 L 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

Yurek to fill: Yes No

Drug: _____

Route: S/C Rectal Other _____

Directions: _____

Quantity: _____ (for 24 hours of coverage)

Physician (PLEASE PRINT CLEARLY):

Name:	CPSO #:
Address:	Cell:
Telephone:	Pager:
Date:	Signature:

**To consult with a community Pharmacist with medication questions
 or if additional medications are needed please call Yurek Specialties at:
 Phone: 519-680-2416, Ext. 404 or 1-888-637-3690**