

Name:	
Health Card Number:	
DOB:	
Address:	

CONTINUOUS AMBULATORY DELIVERY DEVICE PATIENT CONTROLLED ANALGESIA (CADD SOLIS – PCA) PRESCRIPTION / ORDER

DIAGNOSIS:

ALLERGIES: No Yes Please list:

In the event of anaphylaxis, community nursing service provider will follow their specific agency policy.

PRESCRIPTION/ORDERS

CADD Solis PCA Prescription/Orders

Route: Subcutaneous (S.C) Intravenous (I.V) PICC Port-a-cath (PAC)
(Check one)

Drug: _____ **Concentration*:** _____ mg/ml _____ mcg/ml

Continuous Rate: _____ mg/hour _____ mcg/hour

PCA Dose: _____ mg _____ mcg

PCS Lockout: _____ Minutes (Interval between Bolus Doses)

Maximum # Bolus Doses/Hour _____

Reservoir Volume: 50ml 100ml Other: _____ ml

Total Number of Reservoirs: 10 Other: _____

Number of reservoirs to dispense at once: _____ upon request.

Contingency Plan Prescription/Orders

These meds are to be dispensed with pump
 Not necessary as is an updated order only
 Not necessary as has a SRK with contingency medication

To Start: **2 hours** after pump failure. The patient may have:

Drug: _____ **Concentration:** _____ mg/ml

Quantity to be dispensed: _____

Inject: _____ mg s.c. every 4 hours and _____ mg s.c. every 1 hour for breakthrough pain as required.

Resume the pump **2 hours** after last Q4H dose.

Pump Delivery
Pumps required urgently will be delivered within 4 hrs of
Medical Pharmacies receiving a **completed** form.

Required urgently
 Required same day anytime up to 9:00 pm
 Required next day anytime up to 9:00 pm

Special Instructions:
(ie stop oral meds, stop patch in relation to pump initiation, titration, etc)

Prescriber:	College Reg/CPSO #:
Prescriber Phone #:	
Signature:	Date (dd/mm/yy):

If you require assistance completing this form, please contact:
Medical Pharmacies at 1-844-292-7585 ext. 35901.
Fax completed CADD Prescription/Order forms to Home and Community Care Support Services South East at 1-866-839-7299

*Refer to Page 2 on reverse

CADD Solis VIP – PCA Therapy

CADD Solis VIP – PCA Therapy									
CONC	Continuous Rate		Bolus Dose		CONC	Continuous Rate		Bolus Dose	
Mg/mL	Starting Value*** (mg/hr)	Increment (mg)	Starting Value*** (mg)	Increment (mg)	Mcg/mL	Starting Value*** (mcg/hr)	Increment (mcg)	Starting Value*** (mcg)	Increment (mcg)
0.5	0.05	0.01*	0.05	0.05	5	0.50	0.10**	0.25	0.25
1	0.10	0.10*	0.05	0.05	10	1.00	0.10**	0.50	0.50
2	0.20		0.10	0.10	20	2.00		1.00	1.00
4	0.40		0.20	0.20					
5	0.50	0.10	0.25	0.25	30	3.00	0.10**	1.50	1.50
10	1.00		0.50	0.50	40	4.00		2.00	2.00
20	2.00		1.00	1.00					
30	3.00	0.10	1.50	1.50	45	4.50	0.10**	2.25	2.25
40	4.00		2.00	2.00					
50	5.00		2.50	2.50					
* Increment is 0.01 for values between 0.01 and 0.5 Increment is 0.1 for values between 0.5 and 100					**Increment is 0.1 for values between 0.1 and 100 Increment is 1 for values between 100 and 1000				
***Starting Value is the minimum dose that the CADD Solis VIP Pump will deliver with the associated concentration.									
For a Combination of 2 medications or more (in the same reservoir), use the mL unit									
UNIT - ML	0.1mL/hr	0.1mL	0.05mL	0.05mL					

Please contact the pharmacy to discuss concentrations that are not on the above table.

Recommendations for ordering SC route Recommended concentrations based on Daily Dose.		Recommendations for ordering IV route Recommended concentration based on hourly rate It should be equivalent to a minimum of 0.5ml	
Expected Daily Dose	Suggested Concentration	Expected Hourly Rate	Suggested Concentration
1 - 10mg	0.5 mg/ml	0.5mg	1mg/ml
11 – 20 mg	1 mg/ml	1mg	2mg/ml
21 – 50 mg	2 mg/ml	2.5mg	5mg/ml
51-100 mg	5 mg/ml	5mg	10mg/ml
101 – 200 mg	10 mg/ml	10mg	20mg/ml
201 – 500 mg	20 mg/ml	25mg	50mg/ml
501 – 1000 mg	50 mg/ml		