

# HOME AND COMMUNITY CARE SUPPORT SERVICES Central West

Patient Name: \_\_\_\_\_ HCN#: \_\_\_\_\_  
Address: \_\_\_\_\_ Tel#: \_\_\_\_\_  
Date of Birth (day/month/year): \_\_\_\_\_

- Next day delivery, no additional nursing visit required  
 Urgent delivery (within 4 hours) and nurse to visit to initiate medications

### Home and Community Care Support Services Central West – Symptom Management Kit – Prescription Form\*

1. Prescriber confirms patient/SDM agree to continue receiving palliative care in the home and is aware that SMK medications enable timely pain and symptoms management.
2. Nursing service provider to inform attending physician or nurse practitioner within 12 hours regarding change in patient's condition and need for ongoing prescription.
3. Do Not Resuscitate (DNR c) and Expected Death in the Home (EDITH) should be discussed and likely in place.
4. **Fax completed/signed form to HCCSS Central West: 905-796-4671**

Symptoms	Medication	Directions	Quantity	Coverage
Pain and Dyspnea ** Instructions for opioid naïve patients (initial opioid of choice and strike through and rewrite directions if required)	<b>Circle ONE and initial:</b> Hydromorphone (Dilaudid) inj 2 mg/mL <b>OR</b> Morphine inj 15mg/mL <b>OR</b> Hydromorphone inj 10 mg/mL	0.5 – 1 mg subcut q1h prn  1.25 – 2.5 mg subcut q1h prn  Specify directions:	7 amps  5 amps  Specify #	ODB  ODB  ODB
	<b>***For prescriber information: if patient is already on oral hydromorphone/morphine, to convert from patient's usual dose, take total daily dose and calculate half to give parenteral daily dose. Parenteral daily dose should be divided up over 24h to calculate hourly dose.</b>			
Seizure	Lorazepam 1 mg PO	1-2 tabs po/sl q2h prn (crush or dissolve in a small amount of water to put under tongue)	5 tabs	ODB
	Midazolam 5 mg/mL inj 1 mL amp	2.5 - 5 mg subcut q10 min x 3 doses and call Physician/NP	3 amps	LU code 495 Initial _____
Delirium/Agitation	Haloperidol inj 5 mg/mL	1-2 mg subcut q1h prn until settled or x3 and call physician for further instructions	2 amps	ODB
	Methotrimeprazine (Nozinan) 25 mg/mL	6.25 – 25 mg subcut q3h prn (6.25 mg = 0.25 mL) contact Physician/NP before initiating Methotrimeprazine**	3 amps	ODB
Nausea	Haloperidol inj 5 mg/mL	0.5 - 2.5 mg subcut tid prn	Incl. above	ODB
	Olanzapine sublingual (Zyprexa Zydis) 5 mg rapid dissolve tab	2.5 – 5 mg po q8h prn (place ½ or 1 wafer under tongue)	5 tabs/wafers	ODB
Excess Respiratory Secretions		Non- pharmacological – Reposition and education		
	Scopolamine 0.4 mg/mL inj	0.4 mg subcut q4h prn	5 amps	LU code 481 Initial _____
	Atropine 1% Eye Drops	2 drops sublingual or buccal q3h PRN	5 ml	
Fever	Acetaminophen 650 mg suppository prn	administer up to q6h prn	4	ODB
Urinary	Foley catheter:16 Fr OR other catheter size:_____Fr	Insert indwelling catheter prn	1	

\*Refer to Home and Community Care Support Services Central West Adult Palliative Symptom Management Kit Guidelines

Print Prescriber's Name \_\_\_\_\_ Signature \_\_\_\_\_  
Date \_\_\_\_\_ Prescriber's Contact # \_\_\_\_\_ CPSO# \_\_\_\_\_ CNO# \_\_\_\_\_