

Patient Information:		Diagnosis:	
Patient Name:		Health Card No.:	
Address:		Telephone No.:	
Date of Birth (Y/M/D):		Allergies:	

**MRP must be notified when initiated to inform of clinical change and ensure ongoing prescriptions ordered.**  
The following are orders to be used at nursing discretion, please call with any questions or if you are in need of support.

**PRE-DETERMINED SCRIPT – DO NOT MODIFY- if substitution needed send script separately**

Symptoms	Medication	Concentration	Description/Instructions	Quantity Mitte
Pain, Dyspnea	<input type="checkbox"/> Morphine	15mg/ml OR	_____mg sc q 1hr PRN	6 vials dispense 3 vials at a time
	<input type="checkbox"/> Hydromorphone	2mg/ml OR	_____mg sc q 1hr PRN	
	<input type="checkbox"/> Hydromorphone	10mg/ml OR	_____mg sc q 1hr PRN	
Agitation/ Delirium	Haldol	5mg/ml	<b>Mild Delirium:</b> 0.5mg – 1 mg sc q 4hr PRN <b>Moderate/Severe Delirium/Agitation:</b> 2 mg sc q1hr PRN to a max of 3 doses for control, then 2mg sc q 4hr PRN for maintenance. If ineffective, use Nozinan. Please notify MRP.	6 amps dispense 3 amps at a time
	Methotrimeprazine	25mg/ml	<b>Moderate/Severe Delirium:</b> 12.5mg sc q 4hr PRN and call MRP	2 amps
	Lorazepam	0.5mg tabs	<b>Haldol to be attempted first for anxiety/agitation. Please notify MRP prior to use.</b> 0.5-1 mg PO q2hr PRN	4 tabs
Dyspnea refractory to narcotics	Midazolam LU Code 495	5mg/ml	<b>For any refractory symptoms:</b> 1-2 mg sc q1hr PRN – and call MRP for further instructions	2 x 1ml vials R:1
	Lorazepam	0.5 mg tabs	0.5-1 mg PO q2hr PRN	N/A
Terminal Secretions	Glycopyrrolate LU Code 481	0.2mg/ml	<b>For terminal secretions at end of life:</b> 0.4 mg sc q4hr PRN	4x 2ml vials
Seizures	Midazolam	5mg/ml	<b>Seizures lasting &gt;1-2mins:</b> 2.5mg-5mg sc q 15mins PRN to a max of 3 doses – and call MRP	N/A
Nausea	Haldol	5mg/ml	0.5 – 1 mg sc q 4hr PRN	N/A
	Olanzapine ODT	5mg	5mg SL od PRN	3 tabs
Fever	Tylenol Suppository	650mg	For temp > 38.5°C 1 supp PR q4hr PRN	2 supps
Constipation	Bisacodyl	10mg	10mg PR od PRN	2 supps

**Please indicate if additional supplies are needed by checking the box:**

<input type="checkbox"/> Urinary retention	MSCAT147 MSTR51; MSURB101	-	Insert foley PRN (please provide kit) 14 fr will be provided unless otherwise specified_____. *Average size ordered is 14-16fr.	1 Foley/kit & bag
<input type="checkbox"/> Pulmonary edema from Heart failure	Lasix LU Code 481	10mg/ml	20mg sc q 2-4hr PRN for SOB. ***Only indicated for pts with a previous hx of Congestive heart failure and previous use of parenteral Lasix. (pulmonary edema)	2 x 4ml

**Prescriber Information:**

Physician/Nurse Practitioner Name:		CPSO/CNO No.:	
Physician/Nurse Practitioner Signature:		Date:	
Daytime Phone No.:		After hours/On-Call No.:	

After signing for one opiate & signing RX, fax this form to Home and Community Care Support Services Mississauga Halton **905-855-8989**  
Supplies are enough for short-term use (12-24 hours) ONLY. **Please write a prescription with ongoing orders for ANY medication expired or needing refills.**  
Pharmacy Service Provider: Bayshore Specialty Rx: Call 1-888-313-6988 for any questions or concerns. Bayshore Fax 1-888-287-8577