Ontario Health atHome

# Palliative Symptom Response Order Form

Contact Ontario Health atHome at **1-**800-810-0000

Patient Name _____ HCN _____ VC _____ DOB _____

Address _____ City _____ Province _____ Postal Code _____

Patient Phone # _____ Contact Name _____ Contact Phone _____

NB: This order set is intended for a one-time short-term supply of medications (48 hours) if patient becomes unable to swallow. Please send separate prescription for ongoing medication orders.

| Prescriber **Initials** | Medication / Directions | Mitte |
|---|---|---|
| For Pain and/or Dyspnea | | |
| | Morphine_____mg subcut q_____h PRN<br>(suggest 2 – 5 mg subcut q4 h PRN for opioid naive patient)<br>- - - OR - - - | 5 x 1mL of 10 mg/mL (LU 481) |
| | HYDROmorphone_____mg subcut q_____h PRN<br>(suggest 0.5 – 1 mg subcut q4 h PRN for opioid naive patient) | ☐ 5 x 1mL of 2 mg/mL<br>OR<br>☐ 5 x 1mL of 10 mg/mL |
| For Nausea and/or Vomiting | | |
| | Haloperidol 0.5 – 1 mg subcut q4-6 h PRN | 5 x 1mL of 5 mg/mL |
| For Delirium and/or Agitation | | |
| | Haloperidol 1 – 2 mg subcut q2-4 h PRN<br>- - - OR - - - | 5 x 1mL of 5 mg/mL |
| | Methotrimeprazine (Nozinan) 6.25 – 12.5 mg subcut q6-8 h PRN | 5 x 1mL of 25 mg/mL (LU 490) |
| For **End Stage** Wet Respiratory Secretions | | |
| | Scopolamine 0.4 mg subcut q4-6 h PRN<br>- - - OR - - - | 5 x 1mL of 0.4 mg/mL (LU 481) |
| | Glycopyrrolate 0.2 – 0.4 mg subcut q2-4 h PRN | 5 x 1mL of 0.2 mg/mL (LU 481) |
| For Seizures | | |
| | Midazolam 5 mg subcut STAT. Repeat q10 min PRN (max 3 doses) | 3 x 1mL of 5 mg/mL (LU 495) |
| For Fever > 38.5 $^{O}$ C and/or Pain | | |
| | Acetaminophen 650 mg per rectum q4 h PRN | 4 x 650 mg suppositories |
| For Anxiety and/or Dyspnea | | |
| | LORazepam 1 mg oral/sublingual q4-6 h PRN (add drops of water to dissolve) | 10 x 1 mg oral tablet |
| For Urinary Retention | | |
| | Foley Catheter insertion PRN (Size 14 French; or_____) Irrigate with_____mL NS PRN | |

FAX completed Orders to **Ontario Health atHome** Intake & Extended Hours at 1-866-655-6402.

Note: Processing of this order form requires 24 hours ☐ Check here if order is URGENT (within 4 hours)

## Signature

Referring Practitioner Name _____ CPSO/CNO# _____

Address _____

Phone (day) _____ Phone (night) _____

Signature _____ Date _____ Time _____

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