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Regional Pre-Printed Orders for
Palliative Patient - Community Prescription

Form ID: DRDO107357A Rev: June 04, 2020 Page: 1 of 1

DRUG & FOOD ALLERGIES

• **Mandatory** ☐ **Optional: Prescriber check (✓) to initiate, cross out and initial any orders not indicated.**

- Patient with an anticipated prognosis of days (Must be reviewed regularly)
- Patient MUST have an updated Medical Orders for Scope of Treatment (MOST, in alignment with DNR M1/M2) (ADDI105016 / Print Shop # 430438)
- Patient MUST have confirmed home health involvement
- Palliative Benefits (Plan P) submitted. Patient will pay for the medication before Plan P approval (NUXX104902 / Print Shop # 256828 /HLTH 349)
- Please fax this prescription to local home health office and community pharmacy, fax number _____

SYMPTOMS	MEDICATIONS	QUANTITY (no refills)
Pain/Dyspnea	For patients who are not on regular opioids: ☐ **HYDROmorphone** 0.25 mg subcutaneous Q1H PRN OR For patients who are already on regular opioids: ☐ **HYDROmorphone**____mg subcutaneous Q___ H regularly and ☐ **HYDROmorphone**____mg subcutaneous Q___ H PRN ** Duplicate prescription required	☐ HYDROmorphone 2 mg/1 mL x 10 vials OR ☐ HYDROmorphone 10 mg/1 mL x 10 vials ** If the PRN dose ordered is equal to or more than 2 mg, order 10 mg/mL concentration
Restlessness/ Delirium	☐ **haloperidol**____mg subcutaneous Q___ H PRN (less sedating) ☐ **methotrimeprazine**____ mg subcutaneous Q___ H PRN (more sedating)	☐ haloperidol 5 mg/1 mL x 3 ampoules (Combined amount for both restlessness and nausea) ☐ methotrimeprazine 25 mg/1 mL x 10 vials ☐ metoclopramicle 10 mg/2 mL x 10 vials
Nausea	☐ **metoclopramide**____ mg subcutaneous Q____ H PRN (avoid using in a complete bowel obstruction) ☐ **haloperidol**____mg subcutaneously Q___ H PRN	
Anxiety	☐ **LORazepam** ____ mg sublingually Q___ H PRN	☐ LORazepam sublingual 1 mg x 10 tablets
Upper Airway Secretions	☐ **atropine** 1 % eye drops 1 to 4 drops sublingual Q2H PRN	☐ atropine 1 % eye drops x 1 (5 mL bottle)
Seizures Severe Bleeding	☐ **midazolam**____mg subcutaneous Q___ minutes PRN x 2. If ineffective call family doctor or community nurse	☐ midazolam 10 mg/2 mL vials x 5 vials
Other Medications: If client is already on dexamethasone PO, please change to subcutaneous route ☐ **dexamethasone** ____ mg subcutaneous ☐ once every morning OR ☐ twice daily in the morning and at noon		☐ dexamethasone 20 mg/5 mL vial x 1

Date (dd/mm/yyyy)	Time	Prescriber Signature	Printed Name and College ID#