



# Regional Pre-Printed Orders for Palliative Patient - Community Prescription



Form ID: DRDO107357A

Rev: June 04, 2020

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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: <input type="checkbox"/> <b>HYDROmorphone</b> 0.25 mg subcutaneous Q1H PRN OR For patients who are already on regular opioids: <input type="checkbox"/> <b>HYDROmorphone</b> ____mg subcutaneous Q__ H regularly and <input type="checkbox"/> <b>HYDROmorphone</b> ____mg subcutaneous Q__ H PRN ** Duplicate prescription required	<input type="checkbox"/> HYDROmorphone 2 mg/1 mL x 10 vials OR <input type="checkbox"/> 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	<input type="checkbox"/> <b>haloperidol</b> ____mg subcutaneous Q__ H PRN (less sedating) <input type="checkbox"/> <b>methotrimeprazine</b> ____ mg subcutaneous Q__ H PRN (more sedating)	<input type="checkbox"/> haloperidol 5 mg/1 mL x 3 ampoules (Combined amount for both restlessness and nausea) <input type="checkbox"/> methotrimeprazine 25 mg/1 mL x 10 vials
Nausea	<input type="checkbox"/> <b>metoclopramide</b> ____ mg subcutaneous Q__ H PRN (avoid using in a complete bowel obstruction) <input type="checkbox"/> <b>haloperidol</b> ____mg subcutaneously Q__ H PRN	<input type="checkbox"/> metoclopramide 10 mg/2 mL x 10 vials
Anxiety	<input type="checkbox"/> <b>LORazepam</b> ____ mg sublingually Q__ H PRN	<input type="checkbox"/> LORazepam sublingual 1 mg x 10 tablets
Upper Airway Secretions	<input type="checkbox"/> <b>atropine</b> 1 % eye drops 1 to 4 drops sublingual Q2H PRN	<input type="checkbox"/> atropine 1 % eye drops x 1 (5 mL bottle)
Seizures	<input type="checkbox"/> <b>midazolam</b> ____mg subcutaneous Q__ minutes PRN x 2. If ineffective call family doctor or community nurse	<input type="checkbox"/> midazolam 10 mg/2 mL vials x 5 vials
Severe Bleeding		
Other Medications: If client is already on dexamethasone PO, please change to subcutaneous route <input type="checkbox"/> <b>dexamethasone</b> ____ mg subcutaneous <input type="checkbox"/> once every morning OR <input type="checkbox"/> twice daily in the morning and at noon		<input type="checkbox"/> dexamethasone 20 mg/5 mL vial x 1

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