fraserhealth

Regional Pre-Printed Orders for Actively Dying Adults – Community Prescription

Form ID: DRDO107357B Rev: June 01, 2022

DRUG & FOOD ALLERGIES

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

CRITERIA

- Patient with a death anticipated as hours to days (Must be reviewed regularly)
- Patient should have an updated Medical Orders for Scope of Treatment (MOST) in alignment with DNR M1
- Patient MUST have confirmed Home Health involvement
- Palliative Benefits (Plan P) submitted. Patient will pay for the medication before Plan P approval
- Please fax this prescription to local Home Health office ____________________________ (fax) AND fax to community pharmacy____ (name and fax number)

*IMPORTANT NOTE: duplicate opioid prescription must be faxed in addition to this form and original duplicate opioid prescription must be mailed to community pharmacy within 3 days

SYMPTOMS	MEDICATIONS	QUANTITY
Pain/Dyspnea	For patient who is not on a regular opioids: ☐ **HYDROmorphone** 0.25 mg subcutaneous Q1H PRN For patient who is already on regular opioid: ☐ **HYDROmorphone**____mg subcutaneous Q_____H *AND* ☐ **HYDROmorphone**____mg subcutaneous Q_____H PRN NOTE: Divide oral HYDROmorphone in half to get subcutaneous dose	☐ HYDROmorphone 2 mg/1 mL *OR* ☐ HYDROmorphone 10 mg/1 mL Mitte: _________mg (Dispense________mg every_____ days) ** If the PRN dose ordered is equal to or more than 2 mg, order the 10 mg/1 mL concentration
Distressing Restlessness/ Agitation	☐ Less sedating: **haloperidol**_____mg subcutaneous Q_____H PRN ☐ More sedating: **methotrimeprazine**_____mg subcutaneous Q_____H PRN	☐ haloperidol 5 mg/1 mL x 3 vials (Combined amount for both restlessness and nausea); Refill x 3 ☐ methotrimeprazine 25 mg/1 mL x 10 vials; Refill x 3 ☐ metoclopramide 10 mg/2 mL x 10 vials; Refill x 3
Nausea and/or Vomiting	☐ **metoclopramide**_____mg subcutaneous Q_____H PRN (avoid using in a complete bowel obstruction) ☐ **haloperidol**_____mg subcutaneous Q_____H PRN	
Anxiety	☐ **LORazepam**_____mg sublingual Q_____H PRN	☐ LORazepam sublingual 1 mg x 10 tabs; Refill x 3
Upper Airway Secretions	☐ **atropine 1% eye drop** 1 to 4 drops sublingual Q2H PRN (patient may have to pay for this medication)	☐ atropine 1 % eye drop 5 mL bottle x 1; Refill x 1
Seizures Severe Bleeding	CRISIS ORDER FOR COMFORT: ☐ **midazolam**_____mg subcutaneous Q___minutes PRN x 2 doses	☐ midazolam 10 mg/2 mL x 5 vials; Refill x 3
OTHER MEDICATIONS: ☐ **dexamethasone**_____ mg subcutaneous _____________________ (frequency) ☐ Hold all oral medications if unable to swallow * Do not stop fentanyl patch or methadone (contact pharmacist/palliative team to convert methadone to buccal route)		☐ dexamethasone 20 mg/5 mL x 1 vial; Refill x 3

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

Print Shop # 263517