



PAIN & SYMPTOM MANAGEMENT

SINGLE DRUG Infusion Therapy

(For Combined Drugs, refer to Combined Drug Infusion Therapy Form) Note : USE BLACK INK ONLY

DEMOGRAPHICS

Name _____

Address _____

Date of Birth: _____ Phone: _____

HCN: _____

MEDICAL ORDER FORM

CHAMPLAIN LHIN
100-4200 Labelle Street
Ottawa, ON K1J 1J8 613-745-5525

DIAGNOSES/Allergies:

ALL SECTIONS (ROUTE, CONTINGENCY ORDERS, NAME, SIGNATURE, DATE, DEMOGRAPHICS) REQUIRE CLEAR COMPLETION TO AVOID DELAYS IN ADMINISTRATION

*Note: A copy of this referral may be kept in patient's home . Procedures will be taught to patient or reliable person as clinically indicated

SINGLE DRUG INFUSION Route: SC (Subcutaneous) IV (Intravenous) Other _____

Drug: _____ Concentration: _____ mg/mL OR _____ mcg/ mL

Continuous Rate: _____ mg/hr OR _____ mcg/ hr

PCA: No Yes (if yes, complete the following): PCA Dose: _____ mg OR _____ mcg PCA Lockout: q _____ min Max. Doses _____/hr

New cassette(s) needed? No Yes (if yes, complete the following):

Total Qty of Reservoirs (cassettes): _____ # Reservoirs to Dispense at a Time _____ Reservoir Size: 50 mL 100 mL OR _____ mL

TITRATION ORDER REQUESTED: No Yes (complete section)

May increase OR decrease drug by _____ mg/hr or _____ mcg/hr q _____ hr to a MAXIMUM of _____ mg/hr or _____ mcg/hr and MINIMUM of _____ mg/hr or _____ mcg/hr

***MANDATORY* CONTINGENCY ORDER:**

*** Please note that ONLY prescriptions for injectable medications will be filled – For P.O. orders, please give prescription for contingency orders to patient or fax directly to their pharmacy.**

In the event of pump failure, the patient will be cared for according to these contingency plans. The patient may have:

Drug _____ mg OR _____ mcg PO or SC q _____ hr prn after _____ mins of

Pump failure. Resume pump _____ mins after last PO/SC dose.

For injectable medications, please complete the following:

Meds to be sent? Yes No If Yes, concentration: _____ mg/ml OR _____ mcg/ml

of vials to be dispensed _____ Supplies to be sent (for new Infusion orders only)? Yes No

Special Instructions (These are NOT additional prescriptions): E.g. Fentanyl Patch, Titrate bolus instructions, Rotating Opioids

Mandatory (Use separate sheet if required) List all medications for Medication Reconciliation Purposes.

Transferred Medical Responsibility in the community will be to Dr. _____ who has been made aware

Referring Physician Print Name: _____ CPSO # _____

Signature: _____ Date: (dd/mm/yr) _____

Telephone: _____ Fax: _____

Up to 24 hours may be required for infusion to be initiated in the home. Incomplete prescriptions may cause delays in processing your order. Please ensure that contact information is provided so that the pharmacy can reach you should they have questions.

The patient must be receiving Home Care services with the Champlain LHIN in order to process this Infusion Therapy Form. To refer a patient for Home Care services please contact the Champlain LHIN at 310-2222 or visit healthcareathome.ca/champlain/en and complete a [REFERRAL FORM](#) (The Referral Form can be sent concurrently with the Infusion Therapy Form).

Please see below for suggested dosing guideline.

IV Route- Recommended Concentration*			SC Route- Recommended Concentration**			
IV Infusion	Expected Hourly Rate	Suggested Concentration	SC Infusion	Expected Daily SC Dose	Suggested Concentration	
					1 - 10 mg	0.5 mg/ml
	0.5mg	1mg/mL			11 – 20 mg	1 mg/mL
	1mg	2mg/mL			21 – 50 mg	2 mg/mL
	2.5mg	5mg/mL			51-100 mg	5 mg/mL
	5mg	10mg/mL			101 – 200 mg	10 mg/mL
	10mg	20mg/mL			201 – 500 mg	20 mg/mL
	25mg	50mg/mL			501 – 1000 mg	50 mg/mL

*For IV Route, the hourly volume infused must be a minimum of $\geq 0.5\text{mL}$ per hour to maintain patency in line.

**For SC Route, the recommended maximum subcutaneous volume per hour should not exceed 2mL to optimize absorption.

CADD Solis VIP – PCA Therapy

Please contact the pharmacy to discuss concentrations that are not on this table.

CONC	Continuous Rate		Bolus Dose		CONC	Continuous Rate		Bolus Dose	
Mg/mL	Starting Value*** (mg/hr)	Increment (mg)	Starting Value*** (mg)	Increment (mg)	Mcg/mL	Starting Value*** (mcg/hr)	Increment (mcg)	Starting Value*** (mcg)	Increment (mcg)
0.5	0.05	0.01*	0.05	0.05	5	0.50	0.10**	0.25	0.25
1	0.10	0.10*	0.05	0.05	10	1.00	0.10**	0.50	0.50
2	0.20		0.10	0.10	20	2.00		1.00	1.00
4	0.40		0.20	0.20					
5	0.50	0.10	0.25	0.25	30	3.00	0.10**	1.50	1.50
10	1.00		0.50	0.50	40	4.00		2.00	2.00
20	2.00		1.00	1.00					
30	3.00	0.10	1.50	1.50	45	4.50	0.10**	2.25	2.25
40	4.00		2.00	2.00					
50	5.00		2.50	2.50					

* Increment is 0.01 for values between 0.01 and 0.5
Increment is 0.1 for values between 0.5 and 100

**Increment is 0.1 for values between 0.1 and 100
Increment is 1 for values between 100 and 1000

***Starting Value is the minimum dose that the CADD Solis VIP Pump will deliver with the associated concentration.

For a Combination of 2 medications or more (in the same reservoir), use the mL unit

UNIT - ML	0.1mL/hr	0.1mL	0.05mL	0.05mL					

If you have any questions about the orders or medications, please contact the Medical Pharmacy 613-244-4685, and speak to an available Pharmacist.



PAIN & SYMPTOM MANAGEMENT

COMBINED DRUG Infusion

Therapy (For Single Drugs, refer to Single Drug Infusion Therapy Form) Note : USE BLACK INK

DEMOGRAPHICS

Name _____

Address _____

Date of Birth: _____ Phone: _____

HCN: _____

MEDICAL ORDER FORM

CHAMPLAIN LHIN
100-4200 Labelle Street
Ottawa, ON K1J 1J8 613-745-5525

DIAGNOSES/Allergies:

ALL SECTIONS REQUIRE CLEAR COMPLETION TO AVOID DELAYS IN ADMINISTRATION

*Note: A copy of this referral may be kept in patient's home . Procedures will be taught to patient or reliable person as clinically indicated

***Initiation of combined drug therapy must be performed by (or in consultation with) a palliative care specialist or anesthetist**

COMBINED DRUG INFUSION Route: IV (Intravenous) Other: _____

Drug#1 : _____ Concentration: _____ mg/ mL OR _____ mcg/mL

Drug#2 : _____ Concentration: _____ mg/ mL OR _____ mcg/mL

Continuous Rate: _____ ml/hr

PCA: No Yes (if yes, complete the following): PCA Dose: _____ ml PCA Lockout: q _____ min max. Doses per hr: _____

New cassette(s) needed? No Yes (if yes, complete the following):

Total Qty of Reservoirs (cassettes): _____ # Reservoirs to Dispense at a Time _____ Reservoir Size: 50 mL 100 mL or _____ mL

TITRATION ORDER REQUESTED: No Yes (complete section)

May increase OR decrease infusion rate by _____ mL/hr every _____ hr

to a MAXIMUM of _____ mL/hr and MINIMUM of _____ ml/hr

***MANDATORY* CONTINGENCY ORDER: *Please note that ONLY prescriptions for injectable medications will be filled – For P.O. prescriptions, please give prescription for contingency orders to patient or fax directly to their pharmacy.**

In the event of pump failure, the patient will be cared for according to these contingency plans.

Drug : _____ Dose _____ mg OR mcg PO or SC q _____ hr prn
after _____ mins of pump failure. Resume pump _____ # minutes after last PO/SC dose.

FOR INJECTABLE MEDICATIONS, please complete the following:

Drug to be sent? Yes No If Yes, concentration: _____ mg/ml OR _____ mcg/ml # of vials to be dispensed _____

Supplies to be sent (for new Infusion orders only)? Yes No

Special Instructions (No additional prescriptions) E.g. Fentanyl Patch, Titrate bolus instructions, Rotating Opioids

Mandatory (Use separate sheet if required) List all medications for Medication Reconciliation Purposes.

Transferred Medical Responsibility in the community will be to Dr. _____ who has been made aware

Referring Physician: Print Name: _____ **CPSO #** _____

Signature: _____ **Date (dd/mm/yr)** _____

Telephone: _____ **Fax:** _____

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0.5	0.05	0.01*	0.05	0.05	5	0.50	0.10**	0.25	0.25		
1	0.10	0.10*	0.05	0.05	10	1.00	0.10**	0.50	0.50		
2	0.20		0.10	0.10	20	2.00		1.00	1.00		
4	0.40		0.20	0.20							
5	0.50	0.10	0.25	0.25	30	3.00	0.10**	1.50	1.50		
10	1.00		0.50	0.50	40	4.00		2.00	2.00		
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30	3.00	0.10	1.50	1.50	45	4.50	0.10**	2.25	2.25		
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