ANALGESIA PRESCRIPTION ORDER FORM FOR PCA PUMP

Units 9-11, 70 Esna Park Drive,
Markham, ON L3R 6E7
T: 1-888-313-6988
F: 1-888-287-8577

PATIENT INFORMATION:

Patient:____ Birth Date:_________________________

Address:____ City:______________________________

Phone:____ HCN: _____________________________

Allergies: ____

Added Meds: ____

Medication: ○ **Morphine** ○ **Hydromorphone** ○ **Midazolam** ○ **Other:** __________________

Concentration: ______ mg/ml

(*The higher the concentration, the smaller the infusion volume for SC so site will last*)

Route: ○ SC ○ Other :_____________***(If IV, basal rate vol. must be min. 0.5ml/hr)***

Infusion Rate: Starting______ mg/hr; Maximum ______ mg/hr

Breakthrough Bolus Doses: Starting _____ mg; Maximum ______ mg

Breakthrough Bolus Interval: ○ q15 min prn; Maximum: ______ doses/hr

○ q ___ min prn; Maximum:______ doses/hr

Reservoir Size: ○ 100 ml ○ Other: _____ ml

Total Quantity of Reservoirs: ○ 10 (ten) ○ Other: _____

Dispense at each time: ○ 2 (two) ○ Other: _____

Expected Daily Dose	Suggested Conc.
1 – 20 mg	1mg/ml
21 – 50 mg	2mg/ml
51 –100mg	5mg/ml
101-200mg	10mg/ml
201-500mg	20mg/ml
501-1000mg	50mg/ml
>1000mg	100mg/ml

Physician: ____ CPSO: _________________

Address: ____ Phone: _________________ Cell: _______________

Signature:__________________________________ Fax: ____________________ Date: __________________

(Please sign and fax back to Bayshore Specialty Rx and the corresponding CCAC)