

Patient Name: \_\_\_\_\_

Health Card No.: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone No.: \_\_\_\_\_

Date of Birth (Y/M/D): \_\_\_\_\_

<b>Opioid Analgesic (choose one opioid option only and initial)</b>				
<b>MD or NP's Initials</b>	<b>Medication</b>	<b>Directions</b>	<b>Mitte</b>	<b>Coverage</b>
	Morphine 15 mg/ml injectable 1 ml vial		3	ODB
	Hydromorphone 2 mg/ml injectable 1 ml vial		3	ODB
	Hydromorphone 10 mg/ml injectable 1 ml vial		3	ODB

<b>Medication</b>	<b>Directions</b>	<b>Mitte</b>	<b>Coverage</b>
Haloperidol 5 mg/ml Injectable 1 ml vial	For nausea and vomiting: 0.5 – 1 mg. sc q8h prn For Delirium/agitation: 1 - 2 mg. sc q1h prn until controlled then 2 mg. q 6 h sc prn	3	ODB
Prochlorperazine 10 mg Suppository	For nausea and vomiting: 1 supp pr q4h prn	2	ODB
Lorazepam 1 mg Tablet	For sedation: 1 – 2 mg. SL q2h prn (crush tablet and mix with small amount of water)	6	ODB
Midazolam 5mg/ml Injectable 1 ml vial	For sedation: 2 mg. sc q1h prn	2	LU code 495
Scopolamine 0.4 mg/ml Injectable 1 ml vial	For excess respiratory secretions: 0.4 mg. sc q4h prn	6	LU code 481
Acetaminophen 650 mg Suppository	650 mg. pr q4h for temp > 38.5°	2	ODB

Physician/Nurse Practitioner Name: \_\_\_\_\_

CPSO/CNO No.: \_\_\_\_\_

Physician/Nurse Practitioner Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Daytime Phone No.: \_\_\_\_\_

After hours/On-Call Phone No.: \_\_\_\_\_

**Fax to: (905) 855-8989**