HOME AND COMMUNITY CARE SUPPORT SERVICES
Champlain

PAIN & SYMPTOM MANAGEMENT

SINGLE DRUG **Infusion Therapy**

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

MEDICAL ORDER FORM
Home and Community Care Support Services Champlain
100-4200 Labelle Street
Ottawa, ON K1J 1J8 613-745-5525

DEMOGRAPHICS

Name_____

Address_____

Date of Birth:_____Phone:_____

HCN:_____

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:**_____

Confidential when completed. If you have received this form in error, please contact 1-800-538-0520. Fax form to Home and Community Care Support Services Champlain at 613-745-6984 or 1-855-450-8569

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 Home and Community Care Support Services Champlain in order to process this Infusion Therapy Form. To refer a patient for Home Care services please contact Home and Community Care Support Services Champlain 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****		
	Expected Hourly Rate	**Suggested Concentration**		**Expected Daily SC Dose**	**Suggested Concentration**
IV Infusion			**SC Infusion**	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 ≥ 0.5mL 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.

HOME AND COMMUNITY CARE SUPPORT SERVICES
Champlain

PAIN & SYMPTOM MANAGEMENT

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

MEDICAL ORDER FORM

Home and Community Care Support Services Champlain
100-4200 Labelle Street
Ottawa, ON K1J 1J8 613-745-5525

DEMOGRAPHICS

Name_____

Address_____

Date of Birth:_____Phone:_____

HCN:_____

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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CADD Solis VIP – PCA Therapy
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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.