

**DEMOGRAPHICS**

Name \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

HCN: \_\_\_\_\_

**SINGLE DRUG Infusion Therapy**

(For Combined Drugs, refer to Combined Drug Infusion Therapy Form)

Note : USE BLACK INK ONLY

**MEDICAL ORDER FORM**

 Ontario Health atHome  
 100-4200 Labelle Street  
 Ottawa, ON K1J 1J8

 Telephone: 613-745-5525  
 Fax: 613-745-1680

**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 Ontario Health atHome at 613-745-1680.

## ORDERING GUIDELINES

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 Ontario Health atHome in order to process this Infusion Therapy Form. To refer a patient for Home Care services please contact Ontario Health atHome at 1-855-450-8569 or visit [ontariohealthathome.ca/region/champlain/](http://ontariohealthathome.ca/region/champlain/) 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                 |                    |
|--------------|------------------------------|-------------------|---------------------------|-------------------|---------------|-------------------------------|--------------------|----------------------------|--------------------|
| <b>Mg/mL</b> | Starting Value***<br>(mg/hr) | Increment<br>(mg) | Starting Value***<br>(mg) | Increment<br>(mg) | <b>Mcg/mL</b> | Starting Value***<br>(mcg/hr) | Increment<br>(mcg) | Starting Value***<br>(mcg) | Increment<br>(mcg) |
| <b>0.5</b>   | 0.05                         | 0.01*             | 0.05                      | 0.05              | <b>5</b>      | 0.50                          | 0.10**             | 0.25                       | 0.25               |
| <b>1</b>     | 0.10                         | 0.10*             | 0.05                      | 0.05              | <b>10</b>     | 1.00                          | 0.10**             | 0.50                       | 0.50               |
| <b>2</b>     | 0.20                         |                   | 0.10                      | 0.10              | <b>20</b>     | 2.00                          |                    | 1.00                       | 1.00               |
| <b>4</b>     | 0.40                         |                   | 0.20                      | 0.20              |               |                               |                    |                            |                    |
| <b>5</b>     | 0.50                         | 0.10              | 0.25                      | 0.25              | <b>30</b>     | 3.00                          | 0.10**             | 1.50                       | 1.50               |
| <b>10</b>    | 1.00                         |                   | 0.50                      | 0.50              | <b>40</b>     | 4.00                          |                    | 2.00                       | 2.00               |
| <b>20</b>    | 2.00                         |                   | 1.00                      | 1.00              |               |                               |                    |                            |                    |
| <b>30</b>    | 3.00                         | 0.10              | 1.50                      | 1.50              | <b>45</b>     | <b>4.50</b>                   | <b>0.10**</b>      | <b>2.25</b>                | 2.25               |
| <b>40</b>    | 4.00                         |                   | 2.00                      | 2.00              |               |                               |                    |                            |                    |
| <b>50</b>    | 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.

**Ontario Health atHome**

**PAIN & SYMPTOM MANAGEMENT**

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

**MEDICAL ORDER FORM**

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

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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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| <b>Mg/mL</b> | Starting Value***<br>(mg/hr) | Increment<br>(mg) | Starting Value***<br>(mg) | Increment<br>(mg) | <b>Mcg/mL</b> | Starting Value***<br>(mcg/hr) | Increment<br>(mcg) | Starting Value***<br>(mcg) | Increment<br>(mcg) |
| <b>0.5</b>   | 0.05                         | 0.01*             | 0.05                      | 0.05              | <b>5</b>      | 0.50                          | 0.10**             | 0.25                       | 0.25               |
| <b>1</b>     | 0.10                         | 0.10*             | 0.05                      | 0.05              | <b>10</b>     | 1.00                          | 0.10**             | 0.50                       | 0.50               |
| <b>2</b>     | 0.20                         |                   | 0.10                      | 0.10              | <b>20</b>     | 2.00                          |                    | 1.00                       | 1.00               |
| <b>4</b>     | 0.40                         |                   | 0.20                      | 0.20              |               |                               |                    |                            |                    |
| <b>5</b>     | 0.50                         | 0.10              | 0.25                      | 0.25              | <b>30</b>     | 3.00                          | 0.10**             | 1.50                       | 1.50               |
| <b>10</b>    | 1.00                         |                   | 0.50                      | 0.50              | <b>40</b>     | 4.00                          |                    | 2.00                       | 2.00               |
| <b>20</b>    | 2.00                         |                   | 1.00                      | 1.00              |               |                               |                    |                            |                    |
| <b>30</b>    | 3.00                         | 0.10              | 1.50                      | 1.50              | <b>45</b>     | <b>4.50</b>                   | <b>0.10**</b>      | <b>2.25</b>                | 2.25               |
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