

HYDROMORPHONE HCl ORDER FORM

****To Be Delivered via CADD Pump - For Terminally Ill Hospice Patient****

PATIENT INFORMATION

Patient Name: _____

Delivery Address (Home) : _____

DOB: ____/____/____ Phone #: _____

Allergies: _____

Primary Diagnosis: _____

MEDICATION ORDER - HYDROMORPHONE HCl

Concentration (check one):

☐ 5 mg/mL ☐ 20 mg/mL ☐ 30 mg/mL

Volume (check one):

☐ 50 mL ☐ 100 mL ☐ 150 mL

Quantity: _____ bags

Route (check one): ☐ SQ ☐ IV

ADMINISTRATION DIRECTIONS

☐ Standard Pain Control

Infuse at _____ mg/hour.

Provide a bolus of _____ mg every _____ minutes as needed for breakthrough pain.

☐ Moderate to Severe Pain (Limited Titration)

Infuse at _____ mg/hour with a bolus dose of _____ mg every _____ minutes as needed.

May increase infusion rate every 8 hours by _____ mg/hr if $\geq$ _____ boluses are used within 8 hours, to a maximum rate of _____ mg/hr.

☐ High Symptom Burden (Full Titration Protocol)

Infuse at _____ mg/hour with a bolus dose of _____ mg every _____ minutes as needed.

May increase infusion rate every 8 hours by _____ mg/hr, up to a max of _____ mg/hr if patient requires $\geq$ _____ boluses/8 hrs.

If rate is increased, also increase the bolus by _____ mg (same PRN interval), up to a maximum bolus of _____ mg.

SUPPLIES (check all that apply)

☐ PICC ☐ Port ☐ SQ Set / Subcutaneous Site Supplies

PRESCRIBER INFORMATION

Prescriber Name (Printed): _____ Date: _____

Prescriber Signature : _____

DEA #: _____

Office/Facility Address: _____



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