KETAMINE 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 - KETAMINE 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.

Adjustments may be made by provider based on patient response.

SUPPLIES (check all that apply)

☐ PICC ☐ Port ☐ SQ Set / Subcutaneous Site Supplies

PRESCRIBER INFORMATION

Prescriber Name (Printed):_____ Date:_____

Prescriber Signature :_____

DEA #: _____

Office/Facility Address:_____

_____

Bayview Pharmacy

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