



Hope Health Hultar Hospice Center
1085 North Main Street. Providence, RI 02904
Phone: 401-415-4200 Fax 401-351-2813

HMD signature: _____
Date/Time: _____
DEA: _____

Patient Name/Date of Birth: _____
MRN: _____ Room#: _____
Allergies: _____
Diagnosis: _____

Anxiolytic to be administered via CADD pump
*****Hospice Patient that is Terminally Ill*****

Midazolam Continuous Infusion: Concentration 5:1

(Bayview product: 1st dose from Emergency Supply, subsequent doses will be delivered patient-specific)

Route of administration: ☐ Subcutaneous ☐ Intravenous

☐ **Infusion rate:** _____ mg/hour with a bolus of _____ mg every 30 minutes PRN Anxiety, Restlessness, Spasms or 2nd line for Agitation

☐ **Titration:** May increase infusion rate after 1 hour by: _____ mg/hour for use of 2 boluses/1 hour and/or uncontrolled symptoms to a maximum of _____ mg/hour.

☐ **Titration:** If infusion rate is increased, bolus dose is also increased by _____ mg every 30 minutes to a maximum of _____ mg.

☐ Volume: ☐ 50 ml ☐ 100 ml ☐ Other: _____

☐ **Quantity:** _____ bags/cassettes

For all orders: PRN quantity= 100 and 5 refills, For Around the Clock medication: Quantity = 7 days and 5 refills