PHYSICIAN ORDER

HopeHealth
Touching Lives

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

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

Opioid Infusion Orders to be delivered via CADD Pump
*****For Hospice Patient that is Terminally Ill*****

☐ **Morphine**
Concentration: ☐ 5:1 ☐ 20:1 ☐ 30:1 ☐ Other: _____
Route of administration: ☐ Subcutaneous ☐ Intravenous: _____

☐ **Hydromorphone**
Concentration: ☐ 5:1 ☐ 20:1 ☐ 30:1 ☐ Other: _____
Route of administration: ☐ Subcutaneous ☐ Intravenous: _____

Administration Directions:

☐ ***Infusion rate*** of _____ mg/hour with a ***Bolus dose*** of _____ mg every _____ minutes as needed for moderate to severe pain or dyspnea

☐ Clinician ***bolus dose*** (usually 50-150% of the hourly infusion rate) at time of initiation for moderate to severe pain: _____ mg x1

☐ **Titration:** May increase the infusion rate every 8 hours by _____ mg/hour for use of: _____ boluses/8 hours to a maximum of _____ mg/hour.

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

☐ NO TITRATION ORDERS

Volume: ☐ 50 ml ☐ 100 ml ☐ Other: _____
Quantity: _____ bags/cassettes. **Supplies:** ☐ PICC ☐ Port ☐ SQ ☐ Other: _____
Pump Serial # if available: _____
Lock Box Required: Circle YES/ NO

Prescriber (Print) _____ DEA: _____

Prescriber signature: _____ Date: _____

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

☐ **Ketamine** (initiated in the IPU)
Concentration: ☐ 5:1 ☐ 20:1 ☐ 30:1 ☐ Other: _____
Route of administration: ☐ Subcutaneous ☐ Intravenous: _____
Infusion rate: _____ mg/hour Titration: _____
Volume: ☐ 50 ml ☐ 100 ml ☐ Other: _____
Quantity: _____ bags/cassettes **Supplies:** ☐ PICC ☐ Port ☐ SQ ☐ Other: _____

☐ **Dexmedetomidine** (initiated in the IPU)
Concentration: ☐ 40:1 ☐ Other: _____
Route of administration: ☐ Subcutaneous ☐ Intravenous: _____
Infusion rate: _____ mg/hour Titration: _____
Volume: ☐ 50 ml ☐ 100 ml ☐ Other: _____
Quantity: _____ bags/cassettes **Supplies:** ☐ PICC ☐ Port ☐ SQ ☐ Other: _____

☐ **Other:** _____
Concentration: ☐ 1:1 ☐ Other: _____
Route of administration: ☐ Subcutaneous ☐ Intravenous: _____
Infusion rate: _____ mg/hour Titration: _____
Volume: ☐ 50 ml ☐ 100 ml ☐ Other: _____
Quantity: _____ bags/cassettes **Supplies:** ☐ PICC ☐ Port ☐ SQ ☐ Other: _____
Pump Serial if available #: _____
Lock Box Required: Circle YES/ NO

Prescriber (Print): _____ DEA: _____

Prescriber signature: _____ Date: _____