Symptom Response Kit Order Form

Processing of this order form requires 24 hours. If urgent, add to order form, "Urgent - Required within 4 hours" Please sign below for the **ONE** opioid you want included in the kit. No Substitutions or Alterations except in the case of allergy	**Patient:** _____ **Address:** _____ **City:** _____ **Phone:** _____ **DOB:** _____ **HCN Required:** _____

PROCEDURE:

- ☐ 24/7 physician coverage available
- ☐ Physician with Facilitated Access (FA) designation; **OR**
- ☐ Physicians without FA must call Ontario Drug Benefit (ODB) Exception Access Program (EAP) for telephone request for **Midazolam** and **Scopolamine** approval.

Call **ODB EAP at 1-866-811-9893 and press "1"** during business hours Monday to Friday (8:30am-4:00pm).

This form requires a Physicians signature for ONE opioid and at the bottom of form. (indicated by ☆)

Only ONE Opioid may be included in this Kit, and must be signed for in the space provided

Drug	*Prescriber Signature*	Concentration	Quantity	Notify the Physician if any of these symptoms develop
Morphine ***sign→***	☆	**15mg/mL**	5x1mL amps	Call Physician for specific order for opioids for pain or dyspnea
HYDROmorphone ***sign→***	☆ **OR**	**2mg/mL**	5x1mL amps	
HYDROmorphone ***sign→***	☆ **OR**	**10mg/mL**	5x1mL amps	
Midazolam (Versed) Physician without FA– call EAP program		**5mg/mL**	1x10mL amp	For seizures lasting longer than 2 minutes: Give 5 mg subcut STAT and notify the Physician. Repeat every 10 minutes to a total of 3 times if seizure persists. For severe delirium: Call Physician for specific order
Haloperidol (Haldol)		**5mg/mL**	5x1mL amps	For nausea: Give 0.5 mg -1 mg subcut q4hr PRN
Methotrimeprazine (Nozinan)		**25mg/mL**	5x1mL amps	For moderate to severe delirium: Give 6.25 mg - 12.5 mg subcut q4 – 6 hr PRN and notify physician to discuss next
Scopolamine (Hyoscine Hydrobromide) Physician without FA– call EAP program		**0.4mg/mL**	5 x1mL amps	For terminal secretions: Give 0.4 mg subcut q4h PRN and notify Physician to discuss next steps
Dexamethasone (Decadron)		**4mg/mL**	1x5mL amp	Call Physician for specific order
Incidence of urinary retention				Insert Foley catheter PRN

After signing for **one** opiate, calling EAP if necessary & signing RX**, fax this form to WWLHIN 519-883-5555.**

1. Supplies in the kit are enough for short-term use 24 hours until an ongoing prescription can be acquired.
2. Please write a prescription with ongoing orders for ANY medication used from this kit.

Pharmacy Service Provider: **Bayshore Specialty Rx: Call 1-844-607-6362 Ext: 38201 for any questions or concerns.**
Bayshore Fax 1-844-756-5580

☆ **Prescriber Signature** _____ Date (d/m/y) _____

Printed Name _____ **CPSO # Required** _____ Phone # _____