

Symptom Response Kit Order Form

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

Call **ODB EAP at 1-866-811-9893, press "1" then "3"** during business hours Monday to Friday (8:30am-5pm)

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 <i>sign</i> →	☆	15mg/mL	5x1mL amps	Call Physician for specific order for opioids for pain or dyspnea
HYDROmorphine <i>sign</i> →	☆ OR	2mg/mL	5x1mL amps	
HYDROmorphine <i>sign</i> →	☆ OR	10mg/mL	5x1mL amps	
Midazolam (Versed) LU Code: 495		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 steps
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 # _____