



134 Prince Avenue, Suite B
 Bellingham, WA 98226
 Phone (360) 933-4892
 Fax (360) 933-1197

Patient Name: _____

Date of Birth: _____ Weight (kg): _____

IV Access: _____

Allergies: _____

Patient Controlled Analgesia Order Form

◆ Orders are initiated unless crossed out by provider.

Check box to initiate order.

Please complete this form and fax to (360)933-1197. Call our office and our clinical pharmacists will be happy to make therapy recommendations.

Diagnoses: _____ ICD-9: _____

Medication:

Morphine Sulfate Hydromorphone Fentanyl

Other: _____

Administration Route:

IV Subcutaneous

Dosing Parameters:

A. Basal rate: _____ mg/hour mcg/hour

B. Patient controlled bolus dose: _____ mg/hour mcg/hour

C. Bolus dosing interval: 10 min 15 min Other: _____

D. Maximum hourly dose: _____ # Bolus doses/hour mg/hour mcg/hour

E. Quantity to dispense: _____ Days supply mg mcg

- ◆ Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.
- ◆ Flush line with D5W, 0.9% NaCl and/or Heparin 10 units/ml or 100 units/ml per Infusion Solutions protocol.
- ◆ Infusion Reaction Management per Infusion Solutions protocol as needed.

Nursing Orders:

If no central IV access, RN to insert peripheral IV or subcutaneous catheter, rotate site every 3 to 5 days as needed.

May use lidocaine 1%, 0.1ml intradermally to start IV if needed.

Other: _____

Labs:

_____ every _____

_____ every _____

Prescriber Signature

Date

Please Print Name

DEA Number