



477 W. Horton Rd.
 Bellingham, WA 98226
 Phone (360) 933-4892
 Fax (360) 933-1197

Patient Name: _____

Date of Birth: _____ IV Access: _____

Height: _____ Weight: _____

Address: _____

Allergies: _____

Patient Controlled Analgesia Order Form

MAKE SURE TO COMPLETE ALL SECTIONS OF THIS FORM FOR A VALID CII ORDER

Orders are initiated unless crossed out by provider.

Check box to initiate order.

Fax completed form to (360)933-1197. Call our pharmacists for therapy recommendations.

Diagnoses: _____ **ICD-10:** _____

Medication:

Morphine Sulfate

Hydromorphone HCl

Fentanyl

Other: _____

Administration Route:

IV

Subcutaneous

Intrathecal

Dosing Parameters:

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

B. Patient controlled bolus dose (PRN): _____ mg mcg

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

D. Total quantity to dispense with this order: _____ Days supply (max 60) mg mcg

E. Titrate to comfort to a maximum ___ mg/hour mcg/hour, with a ___% bolus every ___ minutes

(**Titration orders strongly recommended for Hospice patients)

F. Is patient terminal? Yes No (**Yes is required for pharmacy to dispense >1 time using this order)

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.

Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).

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 Q 3 to 5 days PRN.

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

Perform weekly dressing change to intrathecal site and monthly pall filter changes, reprogram pump prn.

Other: _____

Prescriber Signature

Date

Print Name

DEA Number

Prescriber Address