Infusion Solutions Inc.
Home Infusion & Specialty Pharmacy
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