2785 Skymark Ave
Mississauga, ON L4W 4Y3
Tel: 905-624-1234
Fax: 905-629-0123
Toll Free Tel: 1-888-289-4028
Toll Free Fax: 1-800-433-7361

NARCOTIC INFUSION PRESCRIPTION

Patient Name: ____________________ CCAC Required Nursing Service: __________ Start date __________ Start Time

D.O.B.: ____________________
Second Patient Identifier Required

Address: ______ Apt # ______ Street # and Name ______ City ______ Postal Code

Rx

Drug: ____________________

Drug: ____________________ (mg/cassette)

Route: ❑ S/C ❑ IV ❑ Epidural ❑ Intrathecal *Continuous Infusion via PCA Pump*

Concentration: __________ mg/mL

Infusion Rate: __________ mg/hr

Bolus: __________ mg q __________ Minutes (max: __________ /hr)

Mitte: __________ X 100 mL cassettes Dispense: __________ cassettes at atime

__________ X 50 mL cassettes

Emergency Backup Analgesic Orders

MD Signature: ____________________ Date: __________

MD Name: ____________________ CPSO #: __________
(Please Print)

Telephone: __________ Pager: __________ Fax: __________

Address: ____________________

**** FOR PHARMACY USE ONLY ****

Drug Name	Total dose/Container	Container		Label Instructions	Compounding Instructions
1 __________	__________ mg	❑ CASS	❑ 100	❑ Reprogram Pump	Add __________ mL of NS
			❑ 50	❑ In Home	
2 __________	__________ mg	❑ CAS QSNS	❑ 100		Remove all Air.
			❑ 50		
or	__________ mL	❑ Other:	__________		

Pump Serial Number: __________ Programmed By: __________ Checked By: __________

Total Units Authorized:

# Units	Production Date	Delivery Date	Delivery Time	Due Date	Lot Number	Rx Entry Initial