

**Symptom Response Kit (SRK)
Prescription Form**

Revised 2019/04/12

Name: _____

Delivery address: _____

HCN: _____

DOB: _____

Phone #: _____

*******Physician / Nurse Practitioner MUST CHECK EACH MEDICATION REQUESTED*******

ALLERGIES						
Symptom	✓	DRUG	RECOMMENDED DOSING Physician/NP use ONLY	ORDER If no order nurse to call physician/NP	Quantity	Coverage
Anxiety Restlessness SOB	<input type="checkbox"/>	Lorazepam 1 mg tab	0.5 -1 tab SL q 2-4 h PRN	____ tabs SL q ____ hr PRN May crush and dissolve in water to put under the tongue	24 tabs	ODB
Seizures	<input type="checkbox"/>	Lorazepam 1 mg tab	Lorazepam: 2 tabs buccal (by lower labial frenulum) STAT then q 15 min x 1	____ tabs buccal STAT then q 15 min x 1 PRN Pull down lower lip and place by frenulum	24 tabs or as ordered for anxiety	ODB
	<input type="checkbox"/>	Midazolam 5 mg/ml (2 ml vials)	5 – 10 mg SC q 15 min PRN	____ mg SC q ____ min PRN x ____ doses	2 x 2 ml vials	LU : 495
Delirium ** nurse to assess using Delirium Screening Tool prior to giving medication	<input type="checkbox"/>	Haloperidol 5 mg/ml (1 ml amps)	Mild: 0.25 – 1 mg SC q 1 – 2 h PRN Moderate: 2 mg SC q1hr PRN	____ mg SC q ____ hr PRN	3 x 1 ml amps	ODB
	<input type="checkbox"/>	Methotrimeprazine 25 mg/ml (1 ml amps)	Mild: 2.5 – 5 mg PO/SC q1hr PRN Moderate: 5 - 12.5 mg PO/SC q1hr PRN Severe: 12.5 – 25 mg SC Stat. Repeat q30 min. up to 3 or 4	____ mg SC q ____ hr PRN	5 x 1 ml amps	ODB
Nausea	<input type="checkbox"/>	Haloperidol 5 mg/ml (1 ml amps)	0.5 – 1 mg SC q 12h PRN	____ mg SC q ____ hr PRN	3 amps or as ordered for delirium	ODB
	<input type="checkbox"/>	Methotrimeprazine 25 mg/ml (1 ml amps)	2.5 – 5 mg PO/SC q 8 – 12 hr PRN. <i>May be titrated up to 5 - 12.5 mg PO/SC q 8 – 12 hours PRN</i>	____ mg SC q ____ hr PRN	5 amps or as ordered for delirium	ODB
Excessive Pulmonary Secretions	<input type="checkbox"/>	Atropine 1% eye drops		1-2 drops SL or buccal q 4-6 hr PRN	1 x 5 mL bottle	ODB
	<input type="checkbox"/>	Scopolamine 0.4 mg/ml (1 ml vials)	0.4 mg SC q 4 hr PRN	____ mg SC q ____ hr PRN	5 x 1 ml vials	LU: 481
	<input type="checkbox"/>	Glycopyrolate 0.2 mg/ml (1 ml vials)	0.4 mg SC q 2 hr PRN	____ mg SC q ____ hr PRN	5 x 1 ml vials	LU: 481
Pain and/or Shortness of Breath - <i>Choose one of:</i>	<input type="checkbox"/>	Hydromorphone 2 mg/ml (1 ml amps) OR		____ mg SC q ____ hr PRN	5 x 1 ml amps	ODB
	<input type="checkbox"/>	Hydromorphone 10 mg/ml (1 ml amps) High Concentration Alert OR		____ mg SC q ____ hr PRN	3 x 1 ml amps	ODB
	<input type="checkbox"/>	Morphine 15 mg/ml (1 ml amps)		____ mg SC q ____ hr PRN	3 x 1 ml amps	ODB
If on PO Dex consider adding SC OR as adjuvant analgesic	<input type="checkbox"/>	Dexamethasone 4 mg/ml	If on PO then order PO dose as SC For pain: 4 mg - 8 mg SC OD to TID	____ mg SC q ____ hr PRN	2 x 5 ml	ODB
If at risk for terminal bleed consider adding	<input type="checkbox"/>	Midazolam 5 mg/ml	5 mg SC q 10 min	5 mg SC X 1 May repeat after 10 min X 1 if needed	2 vials or as ordered for seizures	LU: 495

MRP/NP signature

MRP/NP name

CPSO#/CNO#

Date (yyyy/mm/dd)

Office #

Pager #

Cell #

Fax #

Symptom Response Kit (SRK) Prescription Guidelines

SRK is a temporary or short term solution only.

- The SRK are MD/NP orders to be implemented by a nurse (RN, RPN) when symptoms require urgent intervention to manage acute symptoms and facilitate a comfortable death at home.
- The MRP/NP is to be notified as soon as possible regarding changes in condition necessitating the initiation of orders.
- ALL requested medications must be ticked off.

SRK is appropriate for a patient who:

- is receiving Home and Community Care service supports through the SW LHIN
 - has a PPS of < 50% (**guideline only**)
 - may require unanticipated symptom management
 - has a disease process that is nearing end stage AND an End of Life Plan is in place
-

**DO NOT LEAVE COMPLETED FORMS IN PATIENT'S HOME
ORDERS MUST BE SENT TO PHARMACY**

When complete FAX/SEND to:

Yurek Pharmacy (Oxford, Elgin, London/Middlesex, & Perth
South)

**Fax: 1-888-637-3690 Phone: 1-888-631-
6502**

Brown's Pharmacy (North (Listowel) Grey, Bruce & Huron)

Fax: 519-881-1369 Phone: 1-844-474-757

**** Usual delivery is within 24 hours ** *For urgent delivery please call
Pharmacist***