



**Serenity Hospice
Admitting Orders to Hospice**

Date: _____

Requested Admit Date _____

****Please note if patient has an emergent need call hospice we will send RN and SW to the patients home with in 2 hours of call****

Physician Name:	Patient Name:
Phone number:	Phone #:
Fax Number:	Address:
DEA #:	Primary Contact: Phone #:

Evaluate and admit to Serenity Hospice Services
Terminal diagnosis of:
 In and emergent need hospice medical director may manage symptoms: Yes No
 Hospice medical director to manage end of life symptoms: Yes No
 Please send most recent H&P, Medication list, POLST and face sheet

COMFORT MEDICATIONS

Rx	Strength/Form	Quantity	Directions
Lorazepam (Ativan)	0.5mg tablet	#30	1 tab PO, SL every 4 hours as needed for anxiety or agitation
Atropine solution (ophthalmic gtts)	1%	30 ml bottle	1-2 gtts under the tongue every 4 hours as needed for terminal secretions ***DO NOT PUT IN EYE***
Morphine Sulfate (Roxanol)	20 mg/ml	30 ml	0.25 ml to 0.5 ml PO or SL every hour as needed for pain or air hunger
ABHR Gel (*see below)	per 1 ML syringe	12	Apply 1 ml topically every 4 hours PRN for nausea and vomiting Compound includes *Lorazepam 0.5mg-Diphenhydramine 12.5mg-Haloperidol 0.5mg-Metoclopramide 10 mg
Acetaminophen	650 mg supp	12	1 supp rectally every 4 hours prn for mild pain or fever
Prochlorperazine	25 mg supp	3	1 supp rectally every 12 hours as prn for nausea and vomiting
Optional: Morphine Intolerant Substitute (circle yes if needed)			YES
Oxycodone Oral solution 20mg/ml-quantity 30 ml			0.25 mg to 0.5 ml PO or SL every hour for pain or air hunger

Physician Signature: _____	Date: _____
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*****PLEASE FAX TO 503-639-0699 (PORTLAND) or 503-715-1287 (SALEM)*****