vitalcare of SOUTH DALLAS

HOSPICE ORDER FORM

P : 945.212.3707 | **F :** 866.790.3580

☐ Home Infusion ☐ Alternate Site of Care

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Delivery Address: _____ Patient SSN: _____

City: _____ State: _____ Zip: _____ Phone: _____

☐ *Demographics attached* ☐ *VITAS demographic sheet included (required documentation for admission)*

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK

MEDICAL INFORMATION

Hospice Diagnosis: _____

Treating Diagnosis: _____

Height: _____ Weight: _____ Allergies: _____

Line/Access: _____ # Lumens: _____

Ordering Physician: _____ Phone: _____

SUPPLIES

HOSPICE ORDERS - *Please attach DEA triplicate for all pain management orders if applicable*

[✓] *Check one of the following PCA medications* !

[ ] Hydromorphone IV PCA

Basal Rate:	_____ mg/hour	Bolus Dose:	_____ mg/dose
Loading Dose:	_____ mg	Bolus Frequency:	Every ____ minutes as needed
Lockout Interval:	_____ mg/hour	Total Grams Ordered:	_____
May Titrate to Comfort	☐ Yes ☐ No		

[ ] Morphine IV PCA

Basal Rate:	_____ mg/hour	Bolus Dose:	_____ mg/dose
Loading Dose:	_____ mg	Bolus Frequency:	Every ____ minutes as needed
Lockout Interval:	_____ mg/hour	Total Grams Ordered:	_____
May Titrate to Comfort	☐ Yes ☐ No		

[ ] Fentanyl IV PCA

Basal Rate:	_____ mcg/hour	Bolus Dose:	_____ mcg/dose
Loading Dose:	_____ mcg	Bolus Frequency:	Every ____ minutes as needed
Lockout Interval:	_____ mcg/hour	Total Milligrams Ordered:	_____
May Titrate to Comfort	☐ Yes ☐ No		

HOSPICE INFORMATION

Hospice Agency: _____

Person Submitting Order Signature: _____ Date: _____

Print Name: _____ Call Back Number: _____