



Interior Health
PALLIATIVE JUST IN CASE (JIC)
SYMPTOM MANAGEMENT KIT (SMK)
PRESCRIPTION REQUEST
Physician / Nurse Practitioner Communication

Patient Name (last) _____
 (first) _____
 DOB (dd/mm/yyyy) _____
 PHN _____ MRN _____
 Account / Visit # _____

Date _____

Home Health Centre _____

Phone _____ Fax _____

Pharmacy _____

Phone _____ Fax _____

Dear Physician / Nurse Practitioner: _____ ,

Information

- Palliative Just in Case Symptom Management Kits are being provided to people on the Interior Health Palliative Program who have a low diversion screen risk and it is anticipated that they will need an individualized kit of parenteral medications for rapid symptom relief to support them to stay home.
- They are meant for short-term contingency use only until a regular prescription can be filled by community pharmacies.
- We recognize not all medication will be utilized and will be returned to pharmacy by family following the patient's death.

Please find attached a **"Palliative Just in Case Prescription"** for your patient _____ who has requested to palliate at home and is planning a home based death.

Request

1. Complete and sign the attached **"Palliative Just in Case Prescription"** and fax to the pharmacy and home health centre listed above.
2. Write **duplicate prescriptions** for opioids as noted on the prescription
3. Fax the duplicates immediately to the pharmacy above and put the originals in the mail within three (3) working days.

Any questions or concerns please call _____ at _____ .

Thank you

Permanent part of the health record