northern health
the northern way of caring

Regional Order Set

COPD Exacerbation Discharge Orders

| *PATIENT LABEL*

Allergies: ☐ None known ☐ Unable to obtain	**Weight:**
List with reactions: _____	_____ **kg**

Note:

• **These orders are valid for prescription at the patient's pharmacy.**

• **Make an additonal copy to keep on the patient chart**

• **Fax a copy of the completed 10-111-5221 COPD Exacerbation Discharge Orders to the patient's family physician**

Bronchodilators

*Note: Special authority (1-877-657-1188) must be arranged if prescription is new to the patient (unless prescribed by a respirologist).

Maintenance inhaler #1 (choose one)

☐ *__tiotropium__ (Spiriva) 18 mcg 1 inhalation once daily x 1 handihaler (30 doses)

☐ *__tiotropium__ (Spiriva Respimat) 2.5 mcg 2 inhalations once daily x 1 inhaler

☐ *__umeclidinium__ (Incruse) 62.5 mcg 1 inhalation once daily x 1 inhaler

☐ *__aclidinium__ (Tudorza) 400 mcg 1 inhalation twice daily x 1 inhaler

☐ __ipratropium__ (Atrovent) MDI via spacer 3 puffs qid x 1 inhaler

Maintenance inhaler #2 (choose one)

☐ *__vilanterol__ 25 mcg/__fluticasone__ 100 mcg (Breo) 1 inhalation once daily x 1 inhaler

☐ *__salmeterol__ 50 mcg/__fluticasone__ 500 mcg (Advair) diskus 1 inhalation bid x 1 diskus inhaler

☐ *__salmeterol__ 25 mcg/__fluticasone__ 250 mcg (Advair) metered dose inhaler (MDI) via spacer 2 puffs bid x 1 inhaler

☐ *__budesonide__ 200 mcg/__formoterol__ 6 mcg (Symbicort) 2 inhalations bid x 1 turbohaler

Rescue inhaler(s) (choose one)

☐ __salbutamol__ (Ventolin) MDI via spacer 2 puffs q4h PRN for shortness of breath x 1 inhaler

☐ __ipratropium__ and __salbutamol__ (Combivent Respimat) MDI 1 to 2 inhalations qid PRN (max 6 inhalations/24h) x 1 inhaler

• Community pharmacist please review inhaler technique with patient

Corticosteroids

☐ **predniSONE** _____ mg PO daily x _____ days (to complete 5 day course)

☐ Other: _____

Antibiotics

Specify: _____ mg PO _____ x _____ days (to complete 7 day course)

Physician name: _____   Fax: _____   License: _____

Physician's signature: _____   **Date:** _____   **Time:** _____

10-111-5221 (LC - RPD/VPM 10/17 - Rev. 12/17) **Review by December 2020**