

Palliative Medicine Consult Trigger Sheet

Please consider the following criteria when determining the palliative care needs of your patient:

- Team/Patient/Family needs help with complex decision making and determination of goals of care
- Patient has unresolved level of pain or other symptom distress for greater than 24 hours
- Patient has unmet psychosocial, cultural, or spiritual issues
- Patient has frequent visits to Emergency Department (more than once for the same diagnosis)
- Patient has more than one hospital admission for the same diagnosis in the last 30 days
- Patient has prolonged length of stay (greater than 5 days) without evidence of progress
- Patient has prolonged stay in ICU and/or transferred from ICU to ICU setting without evidence of progress
- Patient is in an ICU setting with documented poor prognosis

CLINICAL ASSESSMENT

- Pain
- Dyspnea
- Nausea (+/- Vomiting)
- Cough
- Delirium
- Insomnia
- Anxiety
- Agitation
- Declining Performance Status
- Psychosocial Issues

PRIMARY DISEASE PROCESS

- Cancer (Metastatic/Recurrent)
- Advanced COPD
- Stroke (with decreased function by at least 50%)
- End Stage Renal Disease
- Advanced Congestive Heart Failure
- Ventilator Dependent
- Catastrophic Illness/Injury
- Other Life-Limiting Disease
- Chronic Disease That Is Now Life-Limiting

CONCOMITANT DISEASE PROCESSES

- Liver Disease
- Diabetes
- Moderate Renal Disease
- Moderate COPD
- Moderate Congestive Heart Failure
- Other Condition Complicating Care



EQUIANALGESIA & THE USE OF OPIOIDS

Severe Pain in the Hospital

- **Morphine 2 mg IV** is equivalent to **Morphine 6 mg PO**, which is approximately equal to **1 Percocet (oxycodone/ acetaminophen) 5/325 mg**.
- **IV opioids** have their full effect **10-20 minutes** after push: if the patient still has severe pain after 20 minutes, push again.
- For persistent severe pain, the opioid dose should be progressively increased by 50 – 100%. No ceiling exists on the number of times a dose may be titrated.
- **IV Hydromorphone (Dilaudid)** is 7 times more potent than IV Morphine: **IV Dilaudid 2 mg = IV Morphine 14 mg = PO Morphine 40 mg = 8 Percocet 5/325**.
- **IV Fentanyl** is **100 times** more potent than **IV morphine: 100 mcg (0.1 mg) IV Fentanyl = 10 mg IV morphine** (see chart).

EQUIANALGESIC DOSING (By convention, compared to 10 mg of injectable morphine.) **All doses below are equivalent.**

Opioid	Injectable	Oral	Ratio: Injectable/Oral
Morphine	10 mg	30 mg	1:3
Oxycodone	Not Available	20-30 mg	--
Hydromorphone (Dilaudid®)	1.5 mg	7.5 mg	1:5
Fentanyl	70-100 mcg (0.07 – 0.1 mg)	--	--
Methadone	0.75 – 1.5 mg	1.5 – 3 mg	1:2

- **Fentanyl patch (Duragesic®):** Rule of thumb: **25 mcg/hr patch** is equivalent to approximately **50 mg of oral morphine a day**: multiply Duragesic **mcg** patch by 2 to get approx. equianalgesic daily oral morphine **mg** dose.
- If **hydrocodone** 10 mg is not providing enough pain relief for 4 hours, prescribe **oxycodone** 5 mg tablets every 4 hours. When **oxycodone** 10 mg no longer provides relief every 4 hours, prescribe oral **morphine** 5-20 mg every 4 hours.
- For **opioid naive** adult patient >60kg with **moderate to severe pain** – start with oral **morphine** 5–10 mg or equivalent every 4 hours.
- Nearly all patients receiving opioid therapy should be on scheduled doses of laxative to prevent constipation.