

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Date of Birth: [Insert DOB]

Address: [Insert Patient Address]

To Whom It May Concern / Home Health Nursing Staff,

This letter serves as formal authorization and instruction for the administration of palliative care medications for the above-named patient. The primary goal of this treatment plan is to ensure comfort and manage symptoms including pain, dyspnea, secretions, and agitation.

Authorized Medications:

- **Pain/Breathlessness:** [Medication Name], [Dosage], [Route], every [Number] hours as needed.
- **Secretions:** [Medication Name], [Dosage], [Route], every [Number] hours as needed.
- **Nausea/Vomiting:** [Medication Name], [Dosage], [Route], every [Number] hours as needed.
- **Agitation/Anxiety:** [Medication Name], [Dosage], [Route], every [Number] hours as needed.

Administration Instructions:

[Insert specific instructions regarding breakthrough dosing or escalation protocols here.]

In the event of a significant change in the patient's condition or if symptoms remain uncontrolled despite the above interventions, please contact the undersigned or the palliative care coordinator immediately.

Sincerely,

Signature: _____

Physician Name: [Insert Name]

Medical License Number: [Insert Number]

Contact Phone: [Insert Phone Number]