



Your care team has requested that a palliative care symptom management kit be put in your home. The kit contains medications, nursing supplies, and clinical tools that are most commonly needed to keep the patient comfortable at the end of their life.

This kit will be locked and can **only be accessed by your doctor or Northern Health home care nurse**. Under no circumstances should a family member or friend try to access the kit. If there is any reason to believe that there is a risk for misuse or theft, please let your home care nurse know immediately. Medications will be monitored and any loss/theft must be reported to RCMP and Health Canada.

The kit is to be **stored at room temperature** in an area in the home that is out of the reach of children, pets, or any individual that may inadvertently try to access the medication. If put in the wrong hands, the medication in this kit could seriously harm an adult, child, or pet. The preferred location would be in the top of a closet in the room that the patient is staying.

When your loved one has passed away or has been admitted to a facility **you must return the kit within twenty-four hours** to the community pharmacy that it came from so they can process all of the necessary paperwork and have it ready if another patient should need the kit. If, for some reason, you are unable to return the kit within twenty four hours please call the pharmacy and they can arrange for someone to pick it up.

If any questions should arise, please call: Pharmacy: \_\_\_\_\_  
City: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

|   |                                 |
|---|---------------------------------|
| Patient name (print): _____   |                                 |
| Kit number: _____   | Date given: _____               |
| Family picking up name (print): _____   | Patient/family signature: _____ |
| <b>Pharmacy staff has checked that medications in kit match medication log.</b> |                                 |
| Pharmacist signature: _____   | Date/time: _____                |

|  |                                 |
|--|---------------------------------|
| Date returned: _____   | Patient/family signature: _____ |
| <b>Pharmacy staff has received kit and checked that medications match medication log. Contents are pharmacy responsibility once kit is returned unless discrepancy is noted at time of return.</b> |                                 |
| Pharmacist signature: _____  | Date/time: _____                |

