Ontario Health atHome

Office Location: Champlain
Telephone: 613-745-5525
Fax: 613-745-6984

Parenteral Therapy Referral (Orders)

Nursing services are primarily provided in clinics, with in-home care only by exception. Prescribers must ensure therapy is appropriate and safe; first dose requests may take longer and are at the nursing provider's discretion. Patients receive self-management teaching and follow-up, and services are not duplicated. Ineligible medications include blood products, naturopathic, and experimental treatments.

Patient Information

HCN Version Code	Surname	(Legal) First Name	Preferred/Chosen Name

Sex Assigned at Birth	Preferred Language
☐ Female ☐ Male ☐ Unknown ☐ Undifferentiated	☐ English ☐ French ☐ Other (Specify):

Date of Birth (dd-mmm-yyyy)	Treatment Address	Telephone

Allergies
☐ Unknown ☐ No ☐ Yes (Specify):

Patient Contact (if other than Patient)	Relationship	Telephone

Primary Care Provider	Telephone

Primary Diagnosis (diagnosis and date of onset required for COVID 19)	Date of Onset (dd-mmm-yyyy)

Relevant Diagnoses to Care

Patient taking beta blockers?	Patient taking ACE-inhibitors?	Height (cm)	Weight (kg)
☐ No ☐ Yes	☐ No ☐ Yes		

Medication/Hydration Orders

1. Medication/Hydration Name

Exceptional access program (EAP) approval form sent?
☐ No ☐ Yes, specify Limited Use code #

Dose	Frequency	Rate	Route

Treatment Duration

Start Date (dd-mmm-yyyy)	End Date (dd-mmm-yyyy)	Duration (in days)

First Dose Information

First Dose Given	Date (dd-mmm-yyyy)	Time (24 hour)
☐ No ☐ Yes, provide date and time given		

Next Community Dose Information

Date Dose Due (dd-mmm-yyyy)	Time Dose Due (24 hour)	Can dose be delayed? (in hours)
		☐ No ☐ 4 ☐ 8 ☐ 12 ☐ 24 ☐ Specify:

2. Medication/Hydration Name

Exceptional access program (EAP) approval form sent?
☐ No ☐ Yes, specify Limited Use code #

Dose	Frequency	Rate	Route

Treatment Duration

Start Date (dd-mmm-yyyy)	End Date (dd-mmm-yyyy)	Duration (in days)

First Dose Information

First Dose Given	Date (dd-mmm-yyyy)	Time (24 hour)
☐ No ☐ Yes, provide date and time given		

Next Community Dose Information

Date Dose Due (dd-mmm-yyyy)	Time Dose Due (24 hour)	Can dose be delayed? (in hours)
		☐ No ☐ 4 ☐ 8 ☐ 12 ☐ 24 ☐ Specify:

Surname	(Legal) First Name	Health Card Number

Route Information

Route

- ☐ Subcutaneous
- ☐ Intramuscular (IM)
- ☐ IV

Peripheral intravenous catheter (PIVC):

- ☐ Short ☐ Long ☐ Midline

Central venous access device (CVAD):

- ☐ Peripherally inserted central catheter (PICC)
- ☐ Hickman
- ☐ Other (specify):

Implanted vascular access devices:

- ☐ Port-a-cath
- ☐ Other (specify):

Line Details

Insertion Date (dd-mmm-yyyy)

_____

Number of lumen(s)

_____

Line Change Frequency
(PIVC and subcutaneous)

Every _____ days and as needed

CVAD length on insertion

Internal: _____ External: _____

CVAD tip location:

_____

☐ Valved ☐ Non-valved

Gripper Size

- ☐ 19GA x ¾" x 8" Tubing, Split Septum Y-site Port
- ☐ 19GA X 1" x 8" Tubing, Split Septum Y-site Port
- ☐ 20GA x 1.25" x 8" Tubing, Split Septum Y-site Port
- ☐ 22GA x ¾" x 8 Tubing, Split Septum Y-site Port
- ☐ Gripper Plus Safety without Y-Site 22GA x 1.25"
- ☐ Other (specify):

Flush/Lock Protocol (Note: Heparin or other locking solution will only be used if ordered by prescriber.)

- ☐ Adult: Standard flushing protocol
- ☐ Adult: Alternative flushing protocol (Specify):
- ☐ Pediatric: Flush protocol (Flush protocol must be individually specified for all pediatric patients)

Dressing Change Instructions

- ☐ Standard dressing protocol
- ☐ Alternative dressing protocol (Specify):

Lab Monitoring

IMPORTANT: The MRP is required to order/monitor initial and ongoing lab results. **Doses will be held** if infusion pharmacy vendor and nursing service provider do not have lab results where required. **Vancomycin and Aminoglycosides (e.g.: Gentamycin) require the prescriber to attach lab values.** ISMP Canada: Monograph-IV-Vancomycin.pdf (ismp-canada.org) and Monograph-IV-Gentamycin for monitoring laboratory results.

- ☐ Prescriber is monitoring the treatment, lab work (if applicable)
- ☐ Other practitioner monitoring the treatment/lab work. Enter contact information below

Monitoring Practitioner Name and Designation	Telephone	Fax

Special Instructions

Please provide any necessary details for **discontinuation** of other medications or any additional considerations (e.g. fluid restrictions):

Prescriber Information

Name and Designation	CPSO # / CNO #	Telephone
Practice Address	**After Hours Contact**	**Fax**
Signature		**Date (dd-mmm-yyyy)**

The information on this form is collected pursuant to the Personal Health Information Protection Act, 2004 ("the Act"). The information will be used for the purposes of assessing, planning, and delivering appropriate health services and supports pursuant to Section 37 of the Act. Questions about this collection should be directed to the Chief Privacy Officer of Ontario Health atHome.

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