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
☐ Female ☐ Male ☐ Unknown ☐ Undifferentiated

Preferred Language
☐ English ☐ French ☐ Other (Specify):

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

Allergies   Attached
☐ 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?

Dose	Frequency	Rate	Route	☐ No ☐ Yes, specify Limited Use code #

Treatment Duration

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

First Dose Information

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

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?

Dose	Frequency	Rate	Route	☐ No ☐ Yes, specify Limited Use code #

Treatment Duration

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

First Dose Information

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

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   ☐ Adult: Alternative (Specify):   Pediatric: (Specify)

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)