

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

Medication/Hydration Orders

1. Medication/Hydration Name

Dose	Frequency	Rate	Route	Exceptional access program (EAP) approval form sent? ☐ 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

Dose	Frequency	Rate	Route	Exceptional access program (EAP) approval form sent? ☐ 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):

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 3/4" 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 3/4" x 8 Tubing, Split Septum
Y-site Port

☐ Gripper Plus Safety without Y-Site 22GA x
1.25"

☐ Other (specify):

Implanted vascular access devices:

☐ Port-a-cath
☐ 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)

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.