

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 <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Undifferentiated			Preferred Language <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other (Specify):	
Date of Birth (dd-mmm-yyyy)		Treatment Address		Telephone
Allergies Attached <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes		Patient taking ACE-inhibitors? <input type="checkbox"/> No <input type="checkbox"/> Yes		Height (cm)
				Weight (kg)

Medication/Hydration Orders

1. Medication/Hydration Name				Exceptional access program (EAP) approval form sent? <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> 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) <input type="checkbox"/> No <input type="checkbox"/> 4 <input type="checkbox"/> 8 <input type="checkbox"/> 12 <input type="checkbox"/> 24 <input type="checkbox"/> Specify:	
2. Medication/Hydration Name				Exceptional access program (EAP) approval form sent? <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> 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) <input type="checkbox"/> No <input type="checkbox"/> 4 <input type="checkbox"/> 8 <input type="checkbox"/> 12 <input type="checkbox"/> 24 <input type="checkbox"/> Specify:	

Surname

(Legal) First Name

Health Card Number

Route Information

Route	Line Details	Gripper Size
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: <input type="checkbox"/> Port-a-cath <input type="checkbox"/> Other (specify):	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: <input type="checkbox"/> Valved <input type="checkbox"/> Non-valved	<input type="checkbox"/> 19GA x 3/4" x 8" Tubing, Split Septum Y-site Port <input type="checkbox"/> 19GA X 1" x 8" Tubing, Split Septum Y-site Port <input type="checkbox"/> 20GA x 1.25" x 8" Tubing, Split Septum Y-site Port <input type="checkbox"/> 22GA x 3/4" x 8 Tubing, Split Septum Y-site Port <input type="checkbox"/> Gripper Plus Safety without Y-Site 22GA x 1.25" <input type="checkbox"/> 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 \(ismp-canada.org\)](http://ismp-canada.org/Monograph-IV-Vancomycin.pdf) and [Monograph-IV-Gentamycin](http://ismp-canada.org/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.