Cancer Care Clinic Medical Order

***Required Fields**

Patient Identification

Diagnosis		**Allergy:**
Venous Access	☐ PICC ☐ Port-a-Cath ☐ Access Port-a-Cath Gripper Needle: ☐ 1 inch 19 G ☐ ¾ inch 19 G ☐ De-access and flushing protocol attached or as per provider agency protocol	
Medication	***Regimen Name:**	
	***Infusion Start Date/Time in Clinic**: (dd-mmm-yyyy)	***Infusor End/ Disconnect Date:** (dd-mmm-yyyy)
	☑ De-Access Chemotherapy **Drug to be De-Accessed: Fluorouracil (5FU) Elastomeric Infusor**	☐ **24 hr purple top** ☐ **46 hr red top** ☐ **48 hr red top**
	Flushing Protocol : ☐ **Port Flush**: Flush with 10 to 20 mL 0.9% sodium chloride (Normal Saline). Lock with 5mL (500 units) Heparin lock flush 100 units/mL intravenously, after access and monthly if not in use. ☐ **PICC Flush**: Flush each lumen with 10 to 20 mL 0.9% sodium chloride (Normal Saline). Each lumen locking solution 3 mL heparin – 100 units/mL concentration (300 units). Flush and lock each lumen after access and every 7 days if not in use.	
	☐ **IV Hydration** (via CADD Pump): Normal Saline 1 L over ___________ hours DAILY for ____________ days. Start after 5FU chemotherapy completed. Start Date:________________ End Date: ____________	
	☐ **Supportive Care Medication**: ☐ Dexamethasone ________ mg IV ☐ DAILY ☐ BID for ____________days. Start Date: ________________ End Date: _________________ ☐ Other: ____	
Wound Care	☑ Change dressings as required when wet or soiled	
***Physician/Nurse Practitioner Information**	**PRINT NAME:**	***OHIP Billing #:**
	***Signature:**	**Date:** (dd-mmm-yyyy)
	Hospital: Humber River Hospital	
	***Phone Number:** 416-242-1000 x. 21518	***Fax Number:** 416-242-1068

Please Note: This form needs to be faxed after sending the referral in Resource Matching and e-Referral (RM&R)