Ontario Health atHome

Cancer Care Clinic Medical Referral Form

	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 ***Complete medical orders for PICC line or Port Flush***	
Medication	☐ IV Medication ☐ IM/SC injections Regimen: **FU(CIV)** continuous infusion – every 28 days (Colorectal) 5 FU _____ (**1000 mg/m2/day**) mg IV daily over 24 hours via CADD pump. Start Date:_____ End Date:_____ After continuous infusion is complete, flush line with 50 mL normal saline. Flush and lock Port with Heparin and de-access Port. ☐ Dose checked by (nurse signature):_____ on _____ (dd/mm/yyyy) ☐ Dose checked by (pharmacist signature):_____on _____ (dd/mm/yyyy) ☐ IV Hydration via CADD pump: Normal Saline 1 L over _____ hours for _____days. Start after 5FU chemo completed. Start Date:_____ End Date: _____ ☐ Supportive Care Medication: ☐ Dexamethasone ____ mg IV every _____for _____days Start Date: _____ End Date: _____ ☐ Ondansetron _____ mg IV every _____ for _____days Start Date: _____ End Date: _____ ☐ Other: Start Date:_____ End Date: _____ ☐ Height : _____ ☐ Weight: _____ ☐ BSA: _____	
Physician Information	Print Name:(MD/NP ONLY)_____ OHIP Billing #:_____ Signature: _____Date:_____(dd/mm/yyyy) Phone Number: 416-242-1000 x 21500 Fax Number: 416-242-1068	