Ontario Health atHome

Cancer Care Clinic Medical Referral Form

<table>
<tr><td colspan="3" align="right">Patient Identification</td></tr>
<tr><td>Diagnosis</td><td></td><td>Allergy:</td></tr>
<tr><td>Home Hydration</td><td colspan="2">Is the client a diabetic? ☐ Yes ☐ No

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

Hydration:
☐ IV Hydration via CADD pump:
Normal Saline 1 L over ______ hours for ________days.
Start Date:________________

☐ Other:

De-Access and Flushing Protocol:
☐ PICC line: Pre and Post infusion, flush each lumen with 10-20 mL 0.9% sodium chloride.
Lock each lumen with 3 mL Heparin – 100 units/mL concentration (300 units).
Flush and lock each lumen every 7 days if not in use.
Change dressing weekly or PRN.

☐ PORT: Pre and Post infusion, flush port with 10 - 20 mL 0.9% sodium chloride.
Lock with 5 mL Heparin – 100 units/mL concentration (500 units).
Flush and lock monthly if not in use.</td></tr>
<tr><td>Physician Information</td><td colspan="2">Print Name:(MD/NP ONLY)______________________ OHIP Billing #:_______________
Signature: ________________________Date:________________(dd/mm/yyyy)
Phone Number: 416-242-1000 x 21500 ______ Fax Number: 416-242-1068</td></tr>
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