



**Cancer Care Clinic Medical Referral Form**

*Patient Identification*

<b>Diagnosis</b>		<b>Allergy:</b>
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<b>Venous Access</b>	<input checked="" type="checkbox"/> PICC <input checked="" type="checkbox"/> De-access and flushing protocol or as per provider agency protocol
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<b>Medication</b>	<p><b>PICC Line Flush/Dressing Protocol:</b></p> <p>PICC or Tunnelled (e.g., Hickman®) Flushing Solution 10-20 mL 0.9% sodium chloride each lumen</p> <p>Each lumen Locking Solution 3 mL heparin - 100 units/ml concentration (300 units)</p> <p>Frequency - Flush and lock every 7 days x 6 months</p> <p>Start on _____.</p> <p><b>PICC Line Dressing:</b></p> <p>Dressing to be changed weekly x 6 months.</p> <p>Dressing to be changed in community starting on _____.</p> <p><input type="checkbox"/> Other: Start Date: _____ End Date: _____</p>
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<b>Physician Information</b>	<p>Print Name:(MD/NP ONLY) _____ OHIP Billing #: _____</p> <p>Signature: _____ Date: _____ (dd/mm/yyyy)</p> <p>Phone Number: <u>416-242-1000 x 21500</u> Fax Number: <u>416-242-1068</u></p>
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