



Oncology Clinic Medical Order *Required Fields

Relevant Diagnosis	
Wound Care	Type: PARASIL CATHETER – MALIGNANT ASCITES Location: _____ <input checked="" type="checkbox"/> Best Practice CHANGE DRESSING WEEKLY AND PRN <input type="checkbox"/> Other Order (Specify): _____
*Medication	* <input type="checkbox"/> IV Medication <input type="checkbox"/> IM/SC INJECTIONS <input type="checkbox"/> IV Hydration/Hypodermoclysis *Drug Name: _____ Dose: _____ Route: _____ Frequency: _____ Duration: _____ Dose Given: _____ Next Dose due in Community: _____ (DD/MM/YY Time) (DD/MM/YY Time) <input type="checkbox"/> De-Access Chemotherapy Drug to be De-Accessed: _____ Date/Time _____ (DD/MM/YY Time) Is the client a diabetic: <input type="checkbox"/> Yes <input type="checkbox"/> No Follow Flushing Protocol <input type="checkbox"/> Yes <input type="checkbox"/> No If No please specify : <input type="checkbox"/> Next dose as soon as services can be arranged <input type="checkbox"/> Position of tip has been confirmed
Drainage Catheter Care	<input type="checkbox"/> PleurX™ <input checked="" type="checkbox"/> ParaSil™ <input type="checkbox"/> Tenckhoff DRAIN _____ mL (maximum 2 Litres at a time) every _____ days and PRN. Call Physician or Nurse Practitioner if ascites drains less than _____ mL.
*Physician Information	PRINT NAME: _____ Hospital: Humber River Hospital *Signature: _____ Date: _____ (dd-mmm-yyyy) *Phone Number: 416-242-1000 x.21500 *Fax Number: 416-242-1068
	*OHIP Billing #:

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