

Hospital Medical Treatment Order
***Required Fields**
 Direct to Clinic Referral

Relevant Diagnosis	
Wound Care	<p>* <input type="checkbox"/> Wound Care as per Best Practice Protocol or Select Wound Management Type:</p> <p>*Location: _____</p> <p><input type="checkbox"/> Pressure Ulcer – Stage: _____</p> <p><input type="checkbox"/> Venous Ulcer – Ankle Brachial Pressure Index (ABPI): _____</p> <p><input type="checkbox"/> Arterial Ulcer</p> <p><input type="checkbox"/> Open Surgical Wound <input type="checkbox"/> Trauma (e.g. burn, skin tear) <input type="checkbox"/> Abscess <input type="checkbox"/> Malignant Wound</p> <p><input type="checkbox"/> Diabetic Foot <input type="checkbox"/> Drain Care (Jackson-Pratt (JP) and Percutaneous drains)</p> <p><input type="checkbox"/> Pilonidal Sinus <input type="checkbox"/> Ostomy</p> <p><input type="checkbox"/> Other (Specify): _____ <input type="checkbox"/> VAC/Pico <input type="checkbox"/> Skin Tear</p>
Wound Care Frequency	<p>* <input type="checkbox"/> Nurse to Assess Frequency <input type="checkbox"/> 2-4 Days <input type="checkbox"/> 4-6 Days <input type="checkbox"/> Weekly</p> <p>* <input type="checkbox"/> Drains / Tubes <input type="checkbox"/> Other (specify): _____</p> <p><i>Frequency of dressing change will be determined by Ontario Health atHome, based on client's progress. Ambulatory Clients will be referred to Community Nursing Clinic. Treatments will be taught and services reduced when appropriate.</i></p> <p><i>Dressings: Wound care products may be substituted to a comparable product based on Ontario Health atHome supply list.</i></p>
Medication Orders	<p> <input type="checkbox"/> Intravenous Medication <input type="checkbox"/> Inter-Muscular Injections</p> <p><input type="checkbox"/> Intravenous Hydration/Hypodermoclysis</p> <p>*Drug Name: _____ Dose: _____ Route: _____</p> <p>Frequency: _____ Duration: _____</p> <p>Dose Given: _____ Next Dose: _____</p> <p style="text-align: center;">(Date/Time dose given in hospital) (Date/Time for next dose to be given)</p> <p><input type="checkbox"/> Peripheral Line <input type="checkbox"/> Midline <input type="checkbox"/> PICC Non-Valved</p> <p><input type="checkbox"/> PICC Valved <input type="checkbox"/> Implanted Port <input type="checkbox"/> Tunneled Catheters</p> <p>*Tip Confirmed: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> De-Access Chemotherapy</p> <p>Drug to be De-Accessed: _____ Date: _____</p> <p>Additional Medication Orders:</p>
Other **Downtime Use ONLY	<p><input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Personal Support <input type="checkbox"/> Physiotherapy</p> <p><input type="checkbox"/> Other (specify): _____</p>
*Physician/ Nurse Practitioner Information	<p>PRINT NAME: _____</p> <p>*Signature: _____ Date: _____</p> <p style="text-align: right;">(dd-mmm-yyyy)</p> <p>*CPSO #: _____ Hospital: _____</p> <p>*Phone Number: _____ *Fax Number: _____</p>

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