



**PATIENT INFORMATION**

\_\_\_\_\_  
*(Patient's Last Name, First Name)*

Home Address: \_\_\_\_\_ DOB (dd-mm-yyyy): \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Health Card # and Version Code: \_\_\_\_\_ Caseload: \_\_\_\_\_

**DIAGNOSIS:** 1) \_\_\_\_\_ 2) \_\_\_\_\_

**Surgical Procedure/Treatment:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(dd-mmm-yyyy)

**Other Significant Medical Information:**  
\_\_\_\_\_

**Allergies:**  No  Unknown  Yes, Specify: \_\_\_\_\_

**Multi-drug Resistant Organism (MRO):**  No  Unknown  Yes, Specify: \_\_\_\_\_

|                            |  |                  |   |                            |  |                           |
|----------------------------|--|------------------|---|----------------------------|--|---------------------------|
| <b>Diagnosis Discussed</b> | With Patient: <input type="checkbox"/> No <input type="checkbox"/> Yes | <b>Prognosis</b> | <input type="checkbox"/> Improve <input type="checkbox"/> Remain Stable | <b>Prognosis Discussed</b> | With Patient: <input type="checkbox"/> No <input type="checkbox"/> Yes | <b>DNR Order in Place</b> |
|                            | With Family: <input type="checkbox"/> No <input type="checkbox"/> Yes  |                  | <input type="checkbox"/> Deteriorate <input type="checkbox"/> Unknown   |                            | With Family: <input type="checkbox"/> No <input type="checkbox"/> Yes  |                           |

The Patient/SDM is aware of the prognosis and should death occur, Physician or Nurse Practitioner (NP) has agreed to make a home visit and sign a death certificate or, will arrange for a Physician substitute in his/her absence -  No  Yes

**Palliative Performance Score (PPS):** \_\_\_\_\_ **Edmonton Symptom Assessment Scale (ESAS):** \_\_\_\_\_

**MEDICAL ORDERS**

**TREATMENT ORDERS**

**Remove chemo bottle** \_\_\_\_\_

Flush:  PICC  Port-a-Cath post medication

Flush:  PICC  Port-a-Cath weekly starting \_\_\_\_\_ and change dressing.

**Follow Flushing Protocol**

| Central Vascular Access Device | Flushing Solution | Locking Solution              |
|--------------------------------|-------------------|-------------------------------|
| PICC                           | 10-20 mL NS       | 3mL of Heparin (100 units/mL) |
| Port-a-Cath                    | 10-20mL NS        | 5mL of heparin (100 units/mL) |

Change dressing as required when wet or soiled

**Clinic/Follow-up Appointment:** \_\_\_\_\_  
(dd-mmm-yyyy)

**Lab Tests:** Type, Frequency: \_\_\_\_\_

Results To: \_\_\_\_\_

Phone #: \_\_\_\_\_ Start Date: \_\_\_\_\_  
(dd-mmm-yyyy)

**Diabetic:**  No  Yes **Beta Blockers:**  No  Yes

**SIGNATURE OF PHYSICIAN / NP:** \_\_\_\_\_ **Phone #:** 905-883-2153

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

CPSO #: \_\_\_\_\_