Ontario Health atHome

Oncology Clinic Medical Order

*Required Fields

Relevant Diagnosis	
Wound Care	Type: _____ Location: _____ ☐ Best Practice _____ ☐ Other Order (Specify): _____
***Medication**	* ☐ IV Medication ☐ IM/SC INJECTIONS ☐ IV Hydration/Hypodermoclysis ***Drug Name:** _____ **Dose:** _____ **Route:** _____ **Frequency:** _____ **Duration:** _____ **Dose Given:** _____ (DD/MM/YY **Time**) **Next Dose due in Community:** _____ (DD/MM/YY **Time**) ☐ De-Access Chemotherapy **Drug to be De-Accessed:** _____ Date/Time _____ (DD/MM/YY **Time**) Is the client a diabetic: ☐ Yes ☐ No **Follow Flushing Protocol** ☐ Yes ☐ No If No please specify : ☐ Next dose as soon as services can be arranged ☐ Position of tip has been confirmed
Drainage Catheter Care	☐ PleurX™ ☐ ParaSil™ ☐ Tenckhoff
***Physician Information**	**PRINT NAME:** _____ **Hospital**: _____ ***Signature:** _____ **Date:** _____ (dd-mmm-yyyy) ***Phone Number:** ***Fax Number:**
	***OHIP Billing #:**

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