

## Parenteral Therapy Referral (Orders)

Nursing services are primarily provided in clinics, with in-home care only by exception. Prescribers must ensure therapy is appropriate and safe; first dose requests may take longer and are at the nursing provider's discretion. Patients receive self-management teaching and follow-up, and services are not duplicated. Ineligible medications include blood products, naturopathic, and experimental treatments.

### Patient Information

|                                                                                                                                                                   |              |                   |                                                                                                                                  |                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------|----------------------------------------------------------------------------------------------------------------------------------|-----------------------------|
| HCN                                                                                                                                                               | Version Code | Surname           | (Legal) First Name                                                                                                               | Preferred/Chosen Name       |
| Sex Assigned at Birth<br><input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Undifferentiated |              |                   | Preferred Language<br><input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other (Specify): |                             |
| Date of Birth (dd-mmm-yyyy)                                                                                                                                       |              | Treatment Address |                                                                                                                                  | Telephone                   |
| Allergies <input type="checkbox"/> Attached<br><input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes (Specify):               |              |                   |                                                                                                                                  |                             |
| Patient Contact (if other than Patient)                                                                                                                           |              | Relationship      |                                                                                                                                  | Telephone                   |
| Primary Care Provider                                                                                                                                             |              |                   |                                                                                                                                  | Telephone                   |
| Primary Diagnosis (diagnosis and date of onset required for COVID 19)                                                                                             |              |                   |                                                                                                                                  | Date of Onset (dd-mmm-yyyy) |
| Relevant Diagnoses to Care                                                                                                                                        |              |                   |                                                                                                                                  |                             |

|                                                                                           |                                                                                            |             |             |
|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------|-------------|
| Patient taking beta blockers?<br><input type="checkbox"/> No <input type="checkbox"/> Yes | Patient taking ACE-inhibitors?<br><input type="checkbox"/> No <input type="checkbox"/> Yes | Height (cm) | Weight (kg) |
|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------|-------------|

### Medication/Hydration Orders

#### 1. Medication/Hydration Name

|                                                                                                                                     |  |  |  |           |  |  |  |                         |  |  |  |       |  |  |  |                                                                                                                                                                                                                |  |  |  |  |  |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------|--|--|--|-----------|--|--|--|-------------------------|--|--|--|-------|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|
| Dose                                                                                                                                |  |  |  | Frequency |  |  |  | Rate                    |  |  |  | Route |  |  |  | Exceptional access program (EAP) approval form sent?<br><input type="checkbox"/> No <input type="checkbox"/> Yes, specify Limited Use code #                                                                   |  |  |  |  |  |  |  |
| Treatment Duration<br>Start Date (dd-mmm-yyyy)                                                                                      |  |  |  |           |  |  |  | End Date (dd-mmm-yyyy)  |  |  |  |       |  |  |  | Duration (in days)                                                                                                                                                                                             |  |  |  |  |  |  |  |
| First Dose Information<br>First Dose Given<br><input type="checkbox"/> No <input type="checkbox"/> Yes, provide date and time given |  |  |  |           |  |  |  | Date (dd-mmm-yyyy)      |  |  |  |       |  |  |  | Time (24 hour)                                                                                                                                                                                                 |  |  |  |  |  |  |  |
| Next Community Dose Information<br>Date Dose Due (dd-mmm-yyyy)                                                                      |  |  |  |           |  |  |  | Time Dose Due (24 hour) |  |  |  |       |  |  |  | Can dose be delayed? (in hours)<br><input type="checkbox"/> No <input type="checkbox"/> 4 <input type="checkbox"/> 8 <input type="checkbox"/> 12 <input type="checkbox"/> 24 <input type="checkbox"/> Specify: |  |  |  |  |  |  |  |

#### 2. Medication/Hydration Name

|                                                                                                                                     |  |  |  |           |  |  |  |                         |  |  |  |       |  |  |  |                                                                                                                                                                                                                |  |  |  |  |  |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------|--|--|--|-----------|--|--|--|-------------------------|--|--|--|-------|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|
| Dose                                                                                                                                |  |  |  | Frequency |  |  |  | Rate                    |  |  |  | Route |  |  |  | Exceptional access program (EAP) approval form sent?<br><input type="checkbox"/> No <input type="checkbox"/> Yes, specify Limited Use code #                                                                   |  |  |  |  |  |  |  |
| Treatment Duration<br>Start Date (dd-mmm-yyyy)                                                                                      |  |  |  |           |  |  |  | End Date (dd-mmm-yyyy)  |  |  |  |       |  |  |  | Duration (in days)                                                                                                                                                                                             |  |  |  |  |  |  |  |
| First Dose Information<br>First Dose Given<br><input type="checkbox"/> No <input type="checkbox"/> Yes, provide date and time given |  |  |  |           |  |  |  | Date (dd-mmm-yyyy)      |  |  |  |       |  |  |  | Time (24 hour)                                                                                                                                                                                                 |  |  |  |  |  |  |  |
| Next Community Dose Information<br>Date Dose Due (dd-mmm-yyyy)                                                                      |  |  |  |           |  |  |  | Time Dose Due (24 hour) |  |  |  |       |  |  |  | Can dose be delayed? (in hours)<br><input type="checkbox"/> No <input type="checkbox"/> 4 <input type="checkbox"/> 8 <input type="checkbox"/> 12 <input type="checkbox"/> 24 <input type="checkbox"/> Specify: |  |  |  |  |  |  |  |

Surname

(Legal) First Name

Health Card Number

**Route Information****Route**

- ☐ Subcutaneous  
☐ Intramuscular (IM)  
☐ IV

**Peripheral intravenous catheter (PIVC):**

- ☐ Short ☐ Long ☐ Midline

**Central venous access device (CVAD):**

- ☐ Peripherally inserted central catheter (PICC)  
☐ Hickman  
☐ Other (specify):

**Implanted vascular access devices:**

- ☐ Port-a-cath  
☐ Other (specify):

**Line Details**

Insertion Date (dd-mmm-yyyy)

Number of lumen(s)

Line Change Frequency  
(PIVC and subcutaneous)

Every \_\_\_\_\_ days and as needed

CVAD length on insertion

Internal: \_\_\_\_\_ External: \_\_\_\_\_

CVAD tip location:

☐ Valved ☐ Non-valved**Gripper Size**

- ☐ 19GA x ¾" x 8" Tubing, Split Septum  
 Y-site Port  
☐ 19GA X 1" x 8" Tubing, Split Septum  
 Y-site Port  
☐ 20GA x 1.25" x 8" Tubing, Split Septum  
 Y-site Port  
☐ 22GA x ¾" x 8 Tubing, Split Septum  
 Y-site Port  
☐ Gripper Plus Safety without Y-Site 22GA x  
 1.25"  
☐ Other (specify):

**Flush/Lock Protocol (Note: Heparin or other locking solution will only be used if ordered by prescriber.)**

- ☐ Adult: Standard ☐ Adult: Alternative (Specify): ☐ Pediatric: (Specify)

**Dressing Change Instructions**

- ☐ Standard dressing protocol ☐ Alternative dressing protocol (Specify):

**Lab Monitoring**

**IMPORTANT:** The MRP is required to order/monitor initial and ongoing lab results. **Doses will be held** if infusion pharmacy vendor and nursing service provider do not have lab results where required. **Vancomycin and Aminoglycosides (e.g.: Gentamycin) require the prescriber to attach lab values.** ISMP Canada: [Monograph-IV-Vancomycin.pdf \(ismp-canada.org\)](https://www.ismp-canada.org/monographs/monograph-iv-vancomycin) and [Monograph-IV-Gentamycin](https://www.ismp-canada.org/monographs/monograph-iv-gentamycin) for monitoring laboratory results.

- ☐ Prescriber is monitoring the treatment, lab work (if applicable)  
☐ Other practitioner monitoring the treatment/lab work. Enter contact information below

Monitoring Practitioner Name and Designation

Telephone

Fax

**Special Instructions**

Please provide any necessary details for **discontinuation** of other medications or any additional considerations (e.g. fluid restrictions):

**Prescriber Information**

Name and Designation

CPSO # / CNO #

Telephone

Practice Address

After Hours Contact

Fax

Signature

Date (dd-mmm-yyyy)

The information on this form is collected pursuant to the Personal Health Information Protection Act, 2004 ("the Act"). The information will be used for the purposes of assessing, planning, and delivering appropriate health services and supports pursuant to Section 37 of the Act. Questions about this collection should be directed to the Chief Privacy Officer of Ontario Health atHome.

**Hamilton Niagara Haldimand Brant**

# Fax Numbers Overview

**All Community Referrals, Including Primary Care Providers**

Please fax all community referrals to Intake and Extended Hours teams

Fax Number for All

**1-866-655-6402**

For hospital-based referrals, please fax directly to the appropriate Ontario Health atHome hospital office:

**Brantford/Burlington/Haldimand-Norfolk Hospitals**

Brant Community Healthcare System  
Joseph Brant Hospital  
Haldimand War Memorial Hospital  
Norfolk General Hospital  
West Haldimand General Hospital

Fax Number for All:  
**1-866-568-4418**

**Hamilton Hospitals**

Hamilton General Hospital  
Juravinski Hospital  
Juravinski Cancer Centre  
McMaster University Medical Centre  
St. Joseph's Healthcare Hamilton (*Charlton and West 5<sup>th</sup> Campuses*)  
St Peters Hospital  
Satellite Health Facility  
West Lincoln Memorial Hospital

Fax Number for All:  
**1-866-271-7907**

**Niagara Hospitals**

Fort Erie Site  
Hotel Dieu Shaver  
Marotta Family Hospital (*St. Catharines Site*)  
Niagara Falls Site  
Port Colborne Site  
Welland Site

Fax Number for All:  
**1-866-391-9467**