

<b>Confirmed Discharge Date:</b> _____ or within: <input type="checkbox"/> 24 hrs <input type="checkbox"/> 48 hrs <input type="checkbox"/> 72 hrs <input type="checkbox"/> Other									
<b>Diagnosis:</b>		<b>Allergies:</b>		<b>Precautions:</b> <input type="checkbox"/> Contact <input type="checkbox"/> Droplet/Contact <input type="checkbox"/> Droplet <input type="checkbox"/> Airborne					
		<b>Reason for isolation:</b>							
<b>Prognosis (i.e. Months):</b>		<b>Discussed Care Plan with Patient/Caregiver</b> <input type="checkbox"/> Yes <input type="checkbox"/> No							
		<b>Discussed Care Plan with Primary Care Provider</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A							
Palliative Performance Scale (0-100%):    % <input type="checkbox"/> Improve <input type="checkbox"/> Remain Stable <input type="checkbox"/> Maintenance <input type="checkbox"/> Deteriorate									
<b>Service Requested</b>		<i>Note: Eligible patients will receive nursing services within a clinic setting</i>							
<b>Nursing: Wound Care</b>									
<b>As per Integrated Wound Care Pathways</b>									
<input type="checkbox"/> Pilonidal Sinus	<input type="checkbox"/> Diabetic Foot Ulcer	<input type="checkbox"/> Pressure Injury (Stage _____)	<input type="checkbox"/> Maintenance/Chronic Arterial Ulcer						
<input type="checkbox"/> Venous leg Ulcer	<input type="checkbox"/> Surgical Acute	<input type="checkbox"/> Lymphedema	<input type="checkbox"/> Non-Complex Burn	<input type="checkbox"/> D Skin Tear					
<input type="checkbox"/> Cellulitis	<input type="checkbox"/> Surgical Chronic	<input type="checkbox"/> Trauma	<input type="checkbox"/> Other: _____						
Compression Therapy for VIU - requires recent measurements: (ABPI) _____ Date: _____									
<b>NOTE: Wound care products may be substituted with a comparable product based on [ ] [ ] [ ] supply list. Other - refer to "Additional Orders 1"</b>									
<input type="checkbox"/> <b>Nursing: Specialty</b>		<input type="checkbox"/> Rapid Response Nurse <input type="checkbox"/> NP-Palliative-Reason for Referral to NP: _____							
<input type="checkbox"/> <b>Nursing: General</b>		<input type="checkbox"/> Ostomy Care/teaching <input type="checkbox"/> Drain Care/Teaching <input type="checkbox"/> Catheter Care/Teaching <input type="checkbox"/> Enteral Feed							
		<input type="checkbox"/> Palliative Care <input type="checkbox"/> Symptom Management <input type="checkbox"/> Other: _____							
<b>ADDITIONAL ORDERS (attach additional information as needed):</b>									
<input type="checkbox"/> <b>Nursing: IV Medication #1</b>	<b>Drug</b>	<b>Dose</b>	<b>Route</b>	<b>Frequency</b>					
	<b>Duration</b>	<b>First dose given in hospital?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>*Time of administered last dose:</b>						
<input type="checkbox"/> <b>Nursing: IV Medication #2</b>	<b>Drug</b>	<b>Dose</b>	<b>Route</b>	<b>Frequency</b>					
	<b>Duration</b>	<b>First dose given in hospital?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>*Time of administered last dose:</b>						
<b>COVID-19 Therapeutics (Remdesivir)</b>	<input type="checkbox"/> Patient qualifies for REMDESIVIR treatment as per <b>Ontario Health guidelines</b> . Date of COVID-19 symptom onset: _____ <input type="checkbox"/> Remdesivir - 200 mg IV on Day 1, 100 mg IV daily on days 2 and 3 Is this a first dose? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, Dose 1 date _____; Dose 2 date _____								
<input type="checkbox"/> <b>Nursing: IV Hydration</b>	Solution: _____ Rate: _____ Duration: _____ Start: _____								
<input type="checkbox"/> <b>Nursing: Central Lines (Adults)</b>	<input type="checkbox"/> <b>PICC line flush orders:</b> Flush and lock each lumen with 10 ml NaCl 0.9% post infusion, weekly and PRN. <b>Insertion Date:</b> _____ <input type="checkbox"/> <b>Central venous line dressing orders:</b> Cleanse site with chlorhexidine and apply op-site weekly and PRN, change cap weekly. <input type="checkbox"/> <b>Port-a-Cath care orders:</b> Flush and lock port-a-cath with 10 ml NaCl 0.9%. Flush q 1 month when not in use using a non-coring needle. <input type="checkbox"/> <b>Tunneled catheter (e.g. Hickman) flush orders:</b> Flush and lock each lumen with 10 ml NaCl 0.9% weekly.								
<input type="checkbox"/> <b>Additional Recommendations (e.g. OT, PT, Pharmacy Consult, etc.)</b> <b>Weight bearing status:</b> *Note: Eligibility and availability to be assessed and determined by a Ontario Health atHome Care Coordinator ( <b>attach additional information as needed</b> ).									
Patient has been informed to follow up with their Primary Care Provider: <input type="checkbox"/> Yes, within _____ days <input type="checkbox"/> No <input type="checkbox"/> N/A									
<b>Referring Physician/Nurse Practitioner/Other</b> <b>Name (Print):</b> _____ <b>Designation:</b> _____			<b>OHIP Billing #</b>						
			<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20px; height:20px;"></td> <td style="width:20px; height:20px;"></td> <td style="width:20px; height:20px;"></td> <td style="width:20px; height:20px;"></td> <td style="width:20px; height:20px;"></td> <td style="width:20px; height:20px;"></td> <td style="width:20px; height:20px;"></td> <td style="width:20px; height:20px;"></td> </tr> </table> DD/MM/YY						
<b>Signature:</b> _____			<b>Telephone:</b> _____						