

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
Sex Assigned at Birth ☐ Female ☐ Male ☐ Unknown ☐ Undifferentiated		Preferred Language ☐ English ☐ French ☐ Other (Specify):	
Date of Birth (dd-mmm-yyyy)	Treatment Address		Telephone
Allergies Attached ☐ Unknown No 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? ☐ No ☐ Yes	Patient taking ACE-inhibitors? ☐ No ☐ Yes	Height (cm)	Weight (kg)

Medication/Hydration Orders			
1. Medication/Hydration Name			Exceptional access program (EAP) approval form sent? ☐ No ☐ Yes, specify Limited Use code #
Dose	Frequency	Rate	Route
Treatment Duration Start Date (dd-mmm-yyyy) End Date (dd-mmm-yyyy) Duration (in days)			
First Dose Information First Dose Given ☐ No ☐ Yes, provide date and time given			Date (dd-mmm-yyyy) Time (24 hour)
Next Community Dose Information Date Dose Due (dd-mmm-yyyy) Time Dose Due (24 hour) Can dose be delayed? (in hours) ☐ No ☐ 4 ☐ 8 ☐ 12 ☐ 24 ☐ Specify:			
2. Medication/Hydration Name			Exceptional access program (EAP) approval form sent? ☐ No ☐ Yes, specify Limited Use code #
Dose	Frequency	Rate	Route
Treatment Duration Start Date (dd-mmm-yyyy) End Date (dd-mmm-yyyy) Duration (in days)			
First Dose Information First Dose Given ☐ No ☐ Yes, provide date and time given			Date (dd-mmm-yyyy) Time (24 hour)
Next Community Dose Information Date Dose Due (dd-mmm-yyyy) Time Dose Due (24 hour) Can dose be delayed? (in hours) ☐ No ☐ 4 ☐ 8 ☐ 12 ☐ 24 ☐ 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 3/4" 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 3/4" x 8 Tubing, Split Septum Y-site Port ☐ Gripper Plus Safety without Y-Site 22GA x 1.25" ☐ Other (specify):
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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.