Ontario Health atHome

Oncology Clinic Medical Order

*Required Fields

Relevant Diagnosis	
Wound Care	Type: _____ Location: _____ ☐ Best Practice _____ ☐ Other Order (Specify): _____
***Medication**	* ☐ IV Medication **X** ☐ IM/SC INJECTIONS ☐ IV Hydration/Hypodermoclysis ☐ ***Drug Name:** **FILGRASTIM (GRASTOFIL)** **Dose:** ☐ **300 mcg** ☐ **480 mcg** **Route:** **SUBCUT** **Frequency:** **DAILY** **Duration:** **FOR_____DAYS** **Start Date:** _____ **Next Dose due in Community:** _____ (DD/MM/YY **Time**) (DD/MM/YY **Time**) ☐ ***Drug Name:** **PEGFILGRASTIM (LAPELGA)** **Dose:** **6 mg** **Route:** **SUBCUT** **Frequency:** **ONCE** **Duration:** **ONE DOSE** **Start Date:** _____ **Next Dose due in Community:** _____ (DD/MM/YY **Time**) (DD/MM/YY **Time**)
***Physician Information**	**PRINT NAME:** _____ **Hospital**: Humber River Hospital ***Signature:** _____ **Date:** _____ (dd-mmm-yyyy) ***Phone Number:** 416-242-1000 x. 21500 ***Fax Number:** 416-242-1068
	***OHIP Billing #:**

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