



Cancer Care Clinic Medical Referral Form

Patient Identification

Diagnosis		Allergy:
Home Hydration	<p>Is the client a diabetic? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Venous Access:</p> <p><input type="checkbox"/> PICC <input type="checkbox"/> Port-a-Cath</p> <p><input type="checkbox"/> Access Port-a-Cath Gripper Needle: <input type="checkbox"/> 1 inch 19 G <input type="checkbox"/> ¾ inch 19 G</p> <p><input type="checkbox"/> De-access and flushing protocol attached or as per provider agency protocol</p> <p>*Complete medical orders for PICC line or Port Flush</p> <p>Hydration:</p> <p><input type="checkbox"/> IV Hydration via CADD pump:</p> <p> Normal Saline 1 L over _____ hours for _____ days.</p> <p> Start Date: _____</p> <p><input type="checkbox"/> Other:</p> <p>De-Access and Flushing Protocol:</p> <p><input type="checkbox"/> PICC line: Pre and Post infusion, flush each lumen with 10-20 mL 0.9% sodium chloride. Lock each lumen with 3 mL Heparin – 100 units/mL concentration (300 units). Flush and lock each lumen every 7 days if not in use. Change dressing weekly or PRN.</p> <p><input type="checkbox"/> PORT: Pre and Post infusion, flush port with 10 - 20 mL 0.9% sodium chloride. Lock with 5 mL Heparin – 100 units/mL concentration (500 units). Flush and lock monthly if not in use.</p>	
Physician Information	<p>Print Name: (MD/NP ONLY) _____ OHIP Billing #: _____</p> <p>Signature: _____ Date: _____ (dd/mm/yyyy)</p> <p>Phone Number: <u>416-242-1000 x 21500</u> Fax Number: <u>416-242-1068</u></p>	