Ontario Health atHome

Oncology Clinic Medical Order

*Required Fields

Relevant Diagnosis	
Wound Care	Type: **PARASIL CATHETER – MALIGNANT ASCITES** Location: X☐ Best Practice **CHANGE DRESSING WEEKLY AND PRN** ☐ Other Order (Specify):
***Medication**	* ☐ IV Medication ☐ IM/SC INJECTIONS ☐ IV Hydration/Hypodermoclysis ***Drug Name:** **Dose:** **Route:** **Frequency:** **Duration:** **Dose Given:** (DD/MM/YY **Time**) **Next Dose due in Community:** (DD/MM/YY **Time**) ☐ De-Access Chemotherapy **Drug to be De-Accessed:** Date/Time (DD/MM/YY **Time**) Is the client a diabetic: ☐ Yes ☐ No **Follow Flushing Protocol** ☐ Yes ☐ No If No please specify : ☐ Next dose as soon as services can be arranged ☐ Position of tip has been confirmed
Drainage Catheter Care	☐ PleurX™ X ☐ ParaSil™ ☐ Tenckhoff **DRAIN _____mL (maximum 2 Litres at a time) every _____days and PRN.** **Call Physician or Nurse Practitioner if ascites drains less than _____ mL.**
***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)