

Cancer Care Clinic Medical Referral Form
Patient Identification

Diagnosis		Allergy:
Venous Access	<input checked="" type="checkbox"/> Port-a-Cath <input checked="" type="checkbox"/> Access Port-a-Cath Gripper Needle: <input type="checkbox"/> 1 inch 19 G <input type="checkbox"/> ¾ inch 19 G <input checked="" type="checkbox"/> De-access and flushing protocol attached or as per provider agency protocol	
Medication	<p>Port Flush/Dressing Protocol:</p> <p>Port Flush:</p> <p>Flush with 10 to 20 mL 0.9% sodium chloride (Normal Saline).</p> <p>Lock with 5 mL (500 units) heparin lock flush 100 units/mL intravenously.</p> <p>Flush and lock monthly for 6 months.</p> <p>Start on _____.</p> <p><input type="checkbox"/> Other: Start Date: _____ End Date: _____</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>	