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:** **TINZAPARIN (INNOHEP ®)** **Dose:** _____ **UNITS** **Route:** **SUBCUT** **Frequency:** **DAILY** **Duration:** **FOR**_____ **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™ ☐ ParaSil™ ☐ Tenckhoff
***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)