Ontario Health atHome

Hospital Emergency/Outpatient Medical Treatment Order

*Required Fields

☐ **Direct to Clinic Referral**

Relevant Diagnosis	
Wound Care	☐ Wound Care as per Best Practice ☐ Other - Specify: _____ Type: _____ Location: _____ *Is the Patient a Diabetic? ☐ Yes ☐ No
***Medication Orders**	* ☐ Intravenous Medication ☐ Inter-Muscular/Subcutaneous Injections ☐ Intravenous Hydration/Hypodermoclysis ***Drug Name:** _____ **Dose:** _____ **Route:** _____ **Frequency:** _____ **Duration:** _____ **Dose Given:** _____ **Next Dose:** _____ (Date/Time dose given in hospital) (Date/Time for next dose to be given) ☐ Peripheral Line ☐ Midline ☐ PICC Non-Valved ☐ PICC Valved ☐ Implanted Port ☐ Tunneled Catheter *Tip Confirmed: ☐ Yes ☐ No ☐ De-Access Chemotherapy Drug to be De-Accessed: _____ Date: _____ Additional Medication Orders:
Urinary Catheter Care	☐ Re-Insert ☐ **Foley Catheter Care** ☐ **Irrigate with 30 mL Normal Saline PRN** ☐ **Re-Insert/Change (If Required)** ☐ **Discontinued Foley on:** _____ (dd-mmm-yyyy) Comments:
Other ****Downtime* Use ONLY**	☐ Occupational Therapy ☐ Personal Support ☐ Physiotherapy ☐ Other (Specify):
***Physician/ Nurse Practitioner Information**	**PRINT NAME:** _____ ***Signature:** _____ **Date:** _____ (dd-mmm-yyyy) ***CPSO #:** _____ **Hospital:** _____ ***Phone Number:** ***Fax Number:**

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

Signed Physician/NP Medical Orders are <u>not</u> required for Occupational Therapy, Personal Support and Physiotherapy