Ontario Health atHome

Hospital Medical Treatment Order

*Required Fields

☐ **Direct to Clinic Referral**

Relevant Diagnosis	
Wound Care	* ☐ **Wound Care as per Best Practice Protocol or Select Wound Management Type:** *Location: _____ ☐ Pressure Ulcer – Stage: _____ ☐ Venous Ulcer – Ankle Brachial Pressure Index (ABPI): _____ ☐ Arterial Ulcer ☐ Open Surgical Wound ☐ Trauma (e.g. burn, skin tear) ☐ Abscess ☐ Malignant Wound ☐ Diabetic Foot ☐ Drain Care (Jackson-Pratt (JP) and Percutaneous drains) ☐ Pilonidal Sinus ☐ Ostomy ☐ Other (Specify): ☐ VAC/Pico ☐ Skin Tear
Wound Care Frequency	* ☐ **Nurse to Assess Frequency** ☐ 2-4 Days ☐ 4-6 Days ☐ Weekly * ☐ **Drains / Tubes** ☐ Other *(specify)* : _____ *Frequency of dressing change will be determined by Ontario Health atHome, based on client's progress. Ambulatory Clients will be referred to Community Nursing Clinic. Treatments will be taught and services reduced when appropriate.* ***Dressings**: Wound care products may be substituted to a comparable product based on Ontario Health atHome supply list.*
***Medication Orders**	* ☐ Intravenous Medication ☐ Inter-Muscular 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 Catheters *Tip Confirmed: ☐ Yes ☐ No ☐ De-Access Chemotherapy Drug to be De-Accessed: _____ Date: _____ Additional Medication Orders:
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)