Ontario Health atHome

Medical Referral - Mackenzie Health Chemotherapy MHRH Fax: (905) 707-2415

PATIENT INFORMATION

(Patient's Last Name, First Name)

Home Address: _____ **DOB (dd-mm-yyyy):** _____

City: _____ **Postal Code:** _____ **Home Phone #:** _____

Health Card # and Version Code: _____ **Caseload:** _____

DIAGNOSIS: **1)** **2)**

Surgical Procedure/Treatment: **Date:** _____ (dd-mmm-yyyy)

Other Significant Medical Information:

Allergies: ☐ No ☐ Unknown ☐ Yes, Specify:

Multi-drug Resistant Organism (MRO): ☐ No ☐ Unknown ☐ Yes, Specify:

Diagnosis Discussed	**Prognosis**	**Prognosis Discussed**	**DNR Order in Place**
With Patient: ☐ No ☐ Yes With Family: ☐ No ☐ Yes	☐ Improve ☐ Remain Stable ☐ Deteriorate ☐ Unknown	With Patient: ☐ No ☐ Yes With Family: ☐ No ☐ Yes	☐ No ☐ Yes

The Patient/SDM is aware of the prognosis and should death occur, Physician or Nurse Practitioner (NP) has agreed to make a home visit and sign a death certificate or, will arrange for a Physician substitute in his/her absence - ☐ No ☐ Yes

Palliative Performance Score (PPS): Edmonton Symptom Assessment Scale (ESAS):

MEDICAL ORDERS

TREATMENT ORDERS

Remove chemo bottle_____

Flush: ☐ PICC ☐ Port-a-Cath post medication

Flush: ☐ PICC ☐ Port-a-Cath weekly starting _____ and change dressing.

Follow Flushing Protocol

Central Vascular Access Device	Flushing Solution	Locking Solution
PICC	10-20 mL NS	3mL of Heparin (100 units/mL)
Port-a-Cath	10-20mL NS	5mL of heparin (100 units/mL)

Change dressing as required when wet or soiled

Clinic/Follow-up Appointment: _____ *(dd-mmm-yyyy)*

Lab Tests: Type, Frequency: _____

Results To: _____

Phone #: _____ Start Date: _____ *(dd-mmm-yyyy)*

Diabetic: ☐ No ☐ Yes **Beta Blockers:** ☐ No ☐ Yes

SIGNATURE OF PHYSICIAN / NP: _____ **Phone #:** **905-883-2153**

Print Name: _____ Date: _____

CPSO # : _____