Ontario Health atHome

Medical Treatment Order – Remdesivir

*Required Fields

☐ **Direct to Clinic Referral**

Relevant Diagnosis	COVID+
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:** Remdesivir **Dose:** _____ **Route:** _____ **Frequency:** _____ **Duration:** _____ **Dose Given:** _____ **Next Dose:** _____ (Date/Time dose given in hospital) (Date/Time for next dose to be given) Date of COVID-19 symptom onset: _____ Patient on Beta-Blockers: ☐ Yes ☐ No ☐ IV Remdesivir 200 mg once on Day 1 then IV Remdesivir 100 mg on days 2 and 3 **or** ☐ IV Remdesivir 100 mg once daily for 2 days. Date of First dose: _____
Urinary Catheter Care	☐ Re-Insert 1. **Foley Catheter Care** 2. **Irrigate with 30 mL Normal Saline PRN** 3. **Re-Insert/Change (If Required)** 4. **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