Ontario Health atHome

Name: ______________________ BRN: _______________

Address: ________________________________________

City: ________________________ PC: ______________

Phone: ______________________ DOB: _______________

HCN: ____________________________ VC: ___________

*Most Responsible Physician*: ______________________

# Referral Information
# Total Parenteral Nutrition (TPN)

**Primary Diagnosis:**

**Secondary Diagnosis:**

**Service Request** (where feasible, client/caregiver will be taught treatment protocol) Patient Weight ________

☐ Initial Order ☐ Change in prescription ☐ Latex Allergy (complete as applicable)

☐ Order authorizes up to 6 months of TPN for patient

☐ Clinical Nutrition for TPN Management

☐ TPN Initiation Date _________________ (DD/MTH/YYYY)

☐ Central Line maintenance **(Physician or NP to complete Medical orders – Parenteral Therapy WW525)**

☐ In emergencies only, D10W ___ ml/hr x ___ hrs *Completed by: ______________________________

| Total Nutrient Admixture (TNA) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Amino Acid | Dextrose | Na | K | Cl | Acetate | Mg | Phosphate | Ca | Rate |
| ☐ Standard central | 5% | 15% | 35 mmol/L | 30 mmol/L | As per pharmacy calculation | As per pharmacy calculation | 2.5 mmol/L | 15 mmol/L | 4.6 mmol/day | __ml/hr for__hrs |
| ☐GRH/SMGH standard central | 5% | 15% | 35 mEq/L | 40 mEq/L | As per pharmacy calculation | As per pharmacy calculation | 5 mEq/L | 13.6 mmol/L | 2.3 mmol/L | __ ml/hr for__hrs |
| ☐ Other | | | | | As per pharmacy calculation | As per pharmacy calculation | | | | __ ml/hr for__hrs |

☐ 20% SMOFLipids (LU 525)

☐ 20% Intralipids ☐ Other __________ Rate: _________ ml/hr for ____________ hrs.

☐ MVI –12 10 mL/daily Trace elements Micro+6 conc. 1ml/daily Vitamin K (Phytonadione)200mcg/bag daily

☐ Other ______________________________________________

**Total Rate ____ ml/hr. x ____ hours/day To supply: ____ Kcal and ____ g protein per day**

**Patient Goals / Tapering Instructions:**

☐ Lab requisition complete including requests for:

- ☐ release of results to community Dietitian. Include name of agency and fax numbers
- ☐ lab kit for patient so community Nurse able to draw blood

**Blood Work** (check 1 box):

☐ **Wellington -** Specify lab:

☐ **CML –** Specify lab:

☐ **Life Labs –** Specify lab:

☐ **Other**

Nurse to:

- ☐ Draw blood every Monday per protocol. (Electrolytes, BUN, Creatinine, blood sugar, AST, ALP, GGT, Ca, $PO_4$, Mg, CBC, INR/PTT, Total Protein, Albumin)
- ☐ Routine Order effective for course of TPN up to 6 months
- ☐ Other (please specify) ______________________________________

Physician Signaure: ______________________________

Print Name: ______________________ Date: ___________

Registered Dietitian Signature: ______________________

Contact #: ______________________ Date: ___________