Ontario Health atHome

Medical Orders - Parenteral Therapy

Primary Diagnosis ____________________

Sex ☐ M ☐ F Height ________ Weight ________

Serum Creatinine ________ Date ________

Surgical Procedure & Date	Allergies

VENOUS ACCESS INFORMATION / FLUSH INSTRUCTIONS / DRESSING CHANGES *(Physician, RN or LHIN to complete)*

☐ Saline Lock ☐ Midline ☐ PICC ☐ Valved ☐ Open Ended ☐ Tunnelled

☐ Implanted Port ☐ Non-Accessed ☐ Accessed ☐ Active ☐ Inactive

Size of Gripper Needle ______ g x ______ in Length of Catheter Internal ______ cm External ______ cm

Date of Insertion ____________ Size of Catheter ______ Gauge ______ Number of Lumens ______

☐ Flush line and change dressing as per: ☐ Community Protocol WW144 ☐ Hospital Protocol *(please attach)*

☐ Special Instructions:

BLOOD WORK Is bloodwork required? ☐ Yes ☐ No Freq ______ Start Date ________ ☐ Nurse to draw from central line

Has physician completed MOHLTC lab requisition? ☐ Yes ☐ No **Required for Vancomycin (see P&P 8.1.7)*

COVID 19 THERAPEUTICS- Please attach current medication list.

Patient qualifies for Remdesivir treatment as per Ontario Health guidelines COVID-19 Treatment | Ontario Health

Remdesivir - 200 mg IV on Day 1, 100 mg IV on days 2 and 3. Date of symptom onset: ____________________

Is Patient on beta blockers Yes No If yes, does the benefit of Remdesivir outweigh the risk? Yes No

Please note initial dose could may be delayed by next business day if referral received with insufficient processing time.

MEDICATION / SOLUTION ORDER *(Physician must complete)*

Drug ____________ Dose ________

Frequency / Rate ____________

Has first dose been given ☐ Yes ☐ No Route: ☐ SC ☐ IM ☐ IV

First Dose Date / Time ________

Start Date ______ Time ______ LU # ______

Stop Date Time OR # of Days

MEDICATION / SOLUTION ORDER *(Physician must complete)*

Drug ____________ Dose ________

Frequency / Rate ____________

Has first dose been given ☐ Yes ☐ No Route: ☐ SC ☐ IM ☐ IV

First Dose Date / Time ________

Start Date ______ Time ______ LU # ______

Stop Date Time OR # of Days

MEDICATION ORDER FOR PAIN AND SYMPTOM MANAGEMENT PUMP *(Physician must complete)*

Pharmacist Contact Information Phone # 1-844-607-6362 at Bayshore Specialty Rx

Drug: ____________________ Route: ☐ SC ☐ IV

Conc: ______ mg/ml Basal Rate ______ mg/hr Bolus ______ mg q ______ Minutes

Total Quantity x ☐ 50ml ☐ 100ml ☐ 250ml ☐ 500ml Containers Dispense Containers q Days ☐ PRN

PROVISION FOR MISSED DOSE *(Physician must complete)* ☐ Client may miss one dose ☐ Contact physician for specific orders

☐ Backup Emergency OrderDrug ____________________ Route: ☐ S/C ☐ IM

Directions ____________ Quantity (24hr coverage) ____________ Bayshore Rx to supply ☐ Y ☐ N

PRESCRIBER INFORMATION - *I have explained the benefits and risks of parenteral therapy in the home:*

Name (print) ____________________ ☐ MD ☐ NP ☐ RN(EC) Phone # (private) ____________

Signature ____________________ Date ________ CPSO/CNO# ____________

Care Coordinator ____________________ Phone ____________ Ext. ______