Ontario Health atHome

Office Location: 356 Oxford Street West London, ON N6H 1T3
Telephone: 1-800-811-5146 | CPS fax: 1-866-675-0885
***Hospital: Use hospital Ontario Health atHome fax number**

Parenteral Nutrition Order

Patient Information

Surname		First Name	
Home Address			
City		Postal Code	Direct Telephone Number
Health Card Number (HCN)	Version Code	Date of Birth (YYYY-Month-DD)	Private Insurance

Contact Details for Supply Delivery & Care Provision (if different from above)

Surname	First Name
Relationship to Patient	Phone Number
Delivery Address (if different from home address)	
City	Postal Code

Form Instructions

Complete and fax to Ontario Health atHome at 1-519-472-4045 or 1-855-223-2847

Orders are processed between 8am – 8pm (7 days/week)

Referral form must be completed in full to permit processing. Incomplete orders will be returned.

Medical Information

Weight (in kg) Date checked (YYYY-Month-DD)

Fluid Restriction
☐ Required Amount: _____ mL/day

Allergies (list ALL)
☐ No Known Allergies

Pertinent Medical Details
☐ Diabetic Patient ☐ Renal Patient ☐ Cardiac Patient ☐ On Blood Thinners

Vascular Access (required for intravenous infusions)
◯ Midline ◯ Implanted Port ◯ Central Venous Line (PICC, Hickman)

Insertion Date	# of lumen(s)	Valve	Inserted external length	Confirmed on Chest X-ray
		◯ Yes ◯ No		◯ Yes ◯ No

Implanted Port Gripper Plus Size
◯ 19G x 1.87 cm (0.75") ◯ 20G x 1.87 cm (0.75")
◯ 22G x 1.87 cm (0.75") ◯ 22G x 2.5 cm (1")

Insulin Information
Glucometer testing ☐ Frequency:
Insulin orders with parameters:

Comments:

Surname	First Name	HCN

Parenteral Nutrition (Total/Partial)

Diagnosis/Reason for Parenteral Nutrition (PN)

Request Type
◯ Initial ◯ Change ◯ Regular ◯ Urgent

Required Start Date	Duration/ End Date	Dextrose Order if PN Discontinued (or in event of emergency)
		_____ mL at _____ mL/hr (max 250mL/hr)

Formula Type (please specify amount for Custom Formula)

	◯ Standard Formula	◯ Custom Formula
Dextrose	16.6%	
Amino Acids	5%	
Sodium (Na)	35mmol/L	
Potassium (K)	30mmol/L	
Magnesium (Mg)	2.5mmol/L	
Phosphate (PO_4)	15mmol/L	
Calcium (Ca)	5mmol/L	
Trace Elements (Micro+6)	1mL/day	
Multivitamins (Multi-12)	10mL/day	

Additives
☐ Vitamin K to be added weekly (please specify amount) _____
☐ Other additives (please specify)

Infusion Rates

Lipid: _____ mL/hour × _____ hour/day or _____ %
Amino Acid/Dextrose/Additive: _____ mL/hour × _____ hour/day
Combined PN: _____ mL/hour × _____ hour/day
N.B. Pharmacy to adjust chloride and acetate

Comments/Special Instructions

Flush/Lock Protocol

◯ Standard flush protocol (see Community Flush Protocol below)	◯ Use other flush protocol Specify: ◯ Heparin 100 units/mL ◯ Sodium Citrate 4% ◯ Kitelock™ 4%

Community Flush Protocol

The community protocols below are based on best practice. It is the responsibility of the referral source to specify if another protocol is required and include in the Ontario Health atHome Parenteral Therapy Referral Form, under Flushing and Vascular Access section.

Surname	First Name	HCN

Please Note:

- C&S swab of the IV site will be done with a physician's order and completed lab requisition.
- Protocol references to normal saline (N/S) are for sterile injectable unless otherwise indicated.

	Pre- & Post-Infusion	**Maintenance Flush (Inactive Line)**	**Dressing/Site Care**	**Pre- & Post-intermittent TPN**
Peripheral	3-5mL Normal Saline (N/S)	3-5 mL N/S Q24H	Change site when clinically indicated or per community nursing agency protocol.	
Midline	10mL N/S	10mL N/S Q24H		
Central Line/PICC	10-20mL N/S	10-20mL N/S Q7days	Initial dressing change within 48 hours after insertion, then q7days & prn.	10-20 mL N/S
Implanted Port	10-20mL N/S	10-20mL N/S every 4 weeks (*)		10-20 mL N/S (*)
Tunneled Central Venous Access Device (e.g. Hickman)	Flush each lumen weekly and prn with 10mL of 0.9% sodium chloride. If positive/neutral pressure device is used (maxplus), no heparin required. If no positive pressure device then flush is followed by 3mL of100u/mL Heparin lock flush.			
NOTE: Community Nurses will use their clinical judgement to flush central lines with fluid volumes between 10mL - 20mL considering the type/size of catheter, patient profile and type of infusion therapy.				

Referrer Details

Referrer Name and Designation	CPSO/CNO/College Registration	OHIP Billing Number
Phone Number	Fax Number	
Office Address		
City	Postal Code	
Referrer Signature	Date Signed (YYYY-Month-DD)	