

Hospital Narcotic Infusion Therapy Referral Form

Enter "LHIN to Assess" and follow instructions on posters on each hospital unit

Name:			
Address:			Postal Code:
Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> undifferentiated <input type="checkbox"/> unknown	Date of Birth:		Phone:
HCN (mandatory):		Version Code:	
Ordering Physician (PRINT):			
Primary Diagnosis:			
Other Diagnosis Pertinent to Care:			
Height:	Weight:	Blood Pressure:	Diabetic: <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies:			
IF CANCER DIAGNOSIS OR A LIFE LIMITING ILLNESS			
Metastatic Spread: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Describe:			
Ongoing Treatment: <input type="checkbox"/> Palliative <input type="checkbox"/> Curative			
Anticipated Prognosis: <input type="checkbox"/> 0 <6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> Uncertain			
MEDICATION			
<input type="checkbox"/> Morphine <input type="checkbox"/> Hydromorphone <input type="checkbox"/> Other:			
ADDED MEDS			
CONCENTRATION			
mg/mL (Note: The higher the concentration, the smaller the infusion volume to preserve subcutaneous routes)			
ROUTE			
<input type="checkbox"/> sc <input type="checkbox"/> Other: (If IV, basal rate volume must be 0.5 mL/hr)			
INFUSION RATE			
Minimum	mg/hr	Maximum	mg/hr
Starting	mg/hr		
BREAKTHROUGH BOLUS DOSES			
Minimum	mg	Maximum	mg
Starting	mg		
BREAKTHROUGH BOLUS INTERVAL			
<input type="checkbox"/> q 15 min prn	Maximum	doses/hr	<input type="checkbox"/> q min prn Maximum doses/hr
RESERVOIRS			
Reservoir Size	<input type="checkbox"/> 100 mls <input type="checkbox"/> Other:	ml	Total Quantity of Reservoirs <input type="checkbox"/> 10 (ten) <input type="checkbox"/> Other:
DISPENSE AT EACH TIME			
<input type="checkbox"/> 2 (two) <input type="checkbox"/> Other:			
OTHER INFORMATION			
Unless otherwise indicated, Home and Community Care Support Services Central East may determine frequency of treatment, arrange for teaching of patient or other reliable person and/or request assessment from other disciplines.			
ORDERING PHYSICIAN/NURSE PRACTITIONER			
CPSO/ CNO#:		Print Name:	
Signature:		Date:	
CONTACT INFORMATION FOR ORDERING PHYSICIAN			
Phone:		Fax:	
After Hours:			
LAB RESULTS TO BE SENT TO			
Physician/Nurse Practitioner Name:		Fax:	

Central East Hospital Fax Lines

- Campbellford Memorial Hospital
Fax: 1-844-631-5800
- Haliburton Highlands Health Services
Fax: 1-844-709-3779
- Northumberland Hills Hospital
Fax: 1-844-631-5801
- Lakeridge Health Ajax Pickering
Fax: 905-444-2524
- Lakeridge Health Bowmanville
Fax: 1-844-631-5802
- Lakeridge Health Oshawa
Fax: 905-444-2516
- Lakeridge Health Port Perry
Fax: 1-844-631-5803
- Lakeridge Health Whitby
Fax: 905-444-2518
- Ontario Shores
Fax: 1-844-631-5803
- Markham Stouffville Uxbridge Site
Fax: 1-844-631-5803
- Peterborough Regional Health Centre
Fax: 1-855-444-9628
- Scarborough and Rouge Hospital – Birchmount Site
Fax: 1-844-631-5804
- Scarborough and Rouge Hospital – General Campus
Fax: 1-844-631-5805
- Scarborough and Rouge Hospital – Centenary Site
Fax: 1-844-631-5808
- Ross Memorial Hospital
Fax: 1-844-631-5806

