

North East

Patient Details and Demographics

Health Card Number:	Version Code:	Date of Birth (DD/MM/YYYY):	
Surname:		First name(s):	
Address:	City:	Province:	Postal Code:
Phone #:	Alternate Phone #:	Primary Language: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unidentified <input type="checkbox"/> Unknown			
Name of Contact Person (if other than Patient):		Phone #:	
Relationship: <input type="checkbox"/> POA/SDM <input type="checkbox"/> Spouse <input type="checkbox"/> Other (specify):		Alternate Phone #:	

Health Information

Relevant diagnosis:	Reason for Referral:
<input type="checkbox"/> In home pronouncement <input type="checkbox"/> DNR in place <input type="checkbox"/> Patient/Family aware of diagnosis <input type="checkbox"/> End of Life Palliative Performance Score:	
Infection control: <input type="checkbox"/> MRSA Positive <input type="checkbox"/> VRE Positive <input type="checkbox"/> C diff <input type="checkbox"/> TB <input type="checkbox"/> Other:	Allergies:

Services Requested

<input type="checkbox"/> Nursing <input type="checkbox"/> Personal Support <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Social Work <input type="checkbox"/> Speech Language Pathology <input type="checkbox"/> Nutrition
<input type="checkbox"/> Nurse Practitioner Palliative Care *Sudbury, West Nipissing, Sault Ste. Marie, Timmins & District of Temiskaming only
<input type="checkbox"/> Assess for Alternate Programs: <input type="checkbox"/> Hospice *Sudbury, Sault Ste. Marie <input type="checkbox"/> Complex Continuing Care <input type="checkbox"/> LTC/Short-Stay Respite

Previous Opioid Medication needed in last 24-hour period (oral conversion to subcutaneous): _____

DRUG	BASAL INFUSION RATE: For optimum management, we recommend a dosage range. We apply the following auxiliary label to cassette for nursing staff: "Please start with the lowest infusion rate & bolus indicated. May titrate basal rate up IN SMALL INCREMENTS when excessive boluses required in previous 24-hour period."	DEFAULT CONCENTRATION (Others available upon request)
<input type="checkbox"/> Hydromorphone Subcutaneous	<input type="checkbox"/> (0.1mg to 1mg/hr range): _____ to _____ mg/hr <input type="checkbox"/> PRN only	1mg/mL
	<input type="checkbox"/> (0.5mg to 5mg/hr range): _____ to _____ mg/hr	5mg/mL
	<input type="checkbox"/> (1mg to 10mg/hr range): _____ to _____ mg/hr	10mg/mL
	<input type="checkbox"/> (10mg to 20mg/hr range): _____ to _____ mg/hr	20mg/mL
<input type="checkbox"/> Morphine Subcutaneous	<input type="checkbox"/> (0.5mg to 5mg/hr range): _____ to _____ mg/hr	5mg/mL
	<input type="checkbox"/> (5mg to 20mg/hr range): _____ to _____ mg/hr	20mg/mL
	<input type="checkbox"/> (20mg to 40mg/hr range): _____ to _____ mg/hr	40mg/mL
<input type="checkbox"/> Other Subcutaneous	Specify: _____ <input type="checkbox"/> Add 4mg of Dexamethasone to each cassette (for site irritation)	

BOLUS* Subcutaneous _____ mg to _____ mg q.30 minutes PRN (HALF OF BASAL)

Total Quantity Authorized: 5 10 x 100mL Cassettes or Other Quantity: _____
To be dispensed 1 cassette no earlier than q.4 days (considering variables of concentration and bolus frequency)

CHANGE ABOVE ORDER TO PICC LINE Infusion with conversion of appropriate concentration to 250mL bags
(ONLY exceptional cases when subcutaneous site is no longer an option)

ADDITIONAL MEDICATION ORDER: Drug: _____ Concentration: _____ mg/mL
Route: Subcutaneous Peripheral Central Infusion Rate: _____ mg/hr Bolus: _____ mg/ _____ min
Total Quantity: _____ x100mL Release: 1 cassette q. _____ days (Note Stability: Ketamine: 7 days, Midazolam: 10days).

Flush Instructions: Local Nursing Provider protocol unless otherwise specified
 Other (Specify): _____

Site Care: As per Best Practice Guidelines (e.g. Canadian Vascular Other (Specify): _____
Access Association; Registered Nurses' Association of Ontario).

Next dressing change due(DD/MM/YYYY): _____ Note: Radiologic Report confirming PICC line placement must accompany referral

Please note that in rural areas a 48 hour turnaround time may be required. Patients must return to primary care practitioner or local outpatient services to receive therapy or be maintained on alternate route until medication/equipment-supplies are available.

As a practitioner, I understand and agree that it is my responsibility to monitor and follow-up on blood work results to adjust the prescribed dosages and discontinue treatment when applicable.

Physician Name _____ CPSO# _____ Physician Signature _____ Date (DD/MM/YYYY) _____

Community Pharmacist: _____ Date (DD/MM/YYYY): _____

Offices: Toll Free Tel: 1 800 461 2919 Website: <http://healthcareathome.ca/northeast/en>

<input type="checkbox"/> KIRKLAND LAKE Fax: 705 567 9407	<input type="checkbox"/> NORTH BAY Fax: 705 474 0080	<input type="checkbox"/> PARRY SOUND Fax: 1 855 773 4056	<input type="checkbox"/> SAULT STE. MARIE Fax: 705 949 1663	<input type="checkbox"/> SUDBURY Fax: 705 522 3855	<input type="checkbox"/> TIMMINS Fax: 705 360 5554
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