HOME AND COMMUNITY CARE SUPPORT SERVICES
Waterloo Wellington

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. _____