Hamilton Niagara Haldimand Brant LHIN
RLISS de Hamilton Niagara Haldimand Brant

First Dose IV in Community
Risk Assessment Form
(Adult Patients 18 years and older only)

Name:

BRN:

DOB:

PART 1: Patient is eligible for first dose without further assessment (do not need to complete criteria A and B). Select reason for eligibility and complete medication information:

☐ Medication is exempt from first dose assessment requirements, or

☐ Patient has taken the same medication by any route within the past 6 months and did not suffer an adverse reaction

Medication: Date taken (if appropriate):

PART 2 (only complete if patient not eligible in Part 1): First Dose Assessment – Complete Criteria A and B

Criteria A: Information to be collected from referral source

To be eligible for first dose IV in community, response must be "No" to all of Criteria A.

	Yes	No
• History of or documented evidence of having an adverse reaction or allergic reaction to any medication or chemically related compound: Specific Name: If yes, please explain:	☐	☐
• History of serious adverse reaction or allergic reaction of unknown etiology such as anaphylaxis: If yes, please explain:	☐	☐
• Currently receiving experimental drugs, antineoplastic/chemotherapy medications or medications that are known to have severe side effects associated with their administration:	☐	☐
• Current use of beta blockers or corticosteroids (chart provides common examples of beta blockers but is not all inclusive):	☐	☐

Beta Blockers: Generic Name (Trade Name)		Corticosteroids: Generic Name
Acebutolol (Monitan, Sectral)	Nadolol (Corgard)	Hydrocortisone
Atenolol (Tenormin)	Nebivolol (Bystolic)	Prednisone
Bisoprolol (Monocor)	Pindolol (Visken)	Prednisolone
Carvedilol (Coreg)	Propranolol (Inderal)	Dexamethasone
Labetalol (Trandate)	Timolol (Blocadren)	
Metoprolol (Lopressor, Betaloc)		

Criteria B: Information to be collected from patient/POA-PC

To be eligible for first dose IV in community response must be "Yes" to all of Criteria B.

	Yes	No
• Can patient/POA-PC consent to treatment? Name of POA-PC: Telephone Contact:	☐	☐
• Does the patient have a working telephone:	☐	☐
• Will there be a capable adult (18 years of older) present for patient monitoring during, and 8 hours after medication is administered, including overnight if required: Name: Relationship:	☐	☐
• Does patient have ready access to emergency medical service and live within a 30 minute drive to the nearest Emergency Department?	☐	☐

If POA-PC is required to provide consent for service provider to treat and is not present for first dose, CC has confirmed that can be reached during visit (not an eligibility criteria): Yes ☐

Care Coordinator has recommended to patient/ caregiver to have Benadryl available (not an eligibility criteria): Yes ☐

Physician Name: **Phone:**

Care Coordinator: **Date:**

CS.CM.Form # 248 Approved 03.15 Version 15.01