

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"/> DNR in place <input type="checkbox"/> Patient/Family aware of diagnosis <input type="checkbox"/> In home pronouncement <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 (Specify):	

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 Access Association; Registered Nurses' Association of Ontario) Other (Specify): _____

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): _____

North East LHIN 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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