



Fill out or add Addressograph Label

Name: _____
 Gender: _____ D.O.B.(dd/mm/yyyy): ____/____/____
 HCN: _____
 Address: _____

 Phone Number: _____

**CCAC Home Infusion
 Parenteral Medication Form
 PHYSICIAN OR NP ORDERS**

***Contact information is critical for community IV service provision; Please Verify the Care Destination with the client.
 Additional Contact Information: _____**

**Please Complete and Fax both pages of this order form to:
 SWCCAC 519-472-4045 or 1-855-223-2847**

LINE: Peripheral Line Central Line/Port

LIST ALL Known Allergies: _____

ANTIBIOTIC SELECTION #1

- | | |
|--|--|
| <input type="checkbox"/> Cefazolin | <input type="checkbox"/> Clindamycin |
| <input type="checkbox"/> Ceftriaxone | <input type="checkbox"/> Gentamicin** |
| <input type="checkbox"/> Vancomycin* ** | <input type="checkbox"/> Tobramycin |
| <input type="checkbox"/> Metronidazole | <input type="checkbox"/> Colistimethate |
| <input type="checkbox"/> Ciprofloxacin | <input type="checkbox"/> Penicillin G |
| <input type="checkbox"/> Meropenem | <input type="checkbox"/> Ampicillin |
| <input type="checkbox"/> Imipenem/Cilastatin | <input type="checkbox"/> Piperacillin/Tazobactam |
| <input type="checkbox"/> Ertapenem | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> CefTAZidime | |

Dose: _____
Frequency:
 q24h q12h q8h q6h q4h **Other** _____
Duration of remaining in-home treatment:
 _____ Days OR _____ Doses
Last Dose in Hospital:
 Date: _____ Time: _____
First Dose in Home:
 Date: _____ Time: _____

Not Covered by Ontario Drug Benefit:

- | | |
|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Levofloxacin | <input type="checkbox"/> Azithromycin |
| <input type="checkbox"/> Moxifloxacin | <input type="checkbox"/> Cefotaxime |
| <input type="checkbox"/> Erythromycin | |

ANTIBIOTIC SELECTION #2

- | | |
|--|--|
| <input type="checkbox"/> Cefazolin | <input type="checkbox"/> Clindamycin |
| <input type="checkbox"/> Ceftriaxone | <input type="checkbox"/> Gentamicin** |
| <input type="checkbox"/> Vancomycin* ** | <input type="checkbox"/> Tobramycin |
| <input type="checkbox"/> Metronidazole | <input type="checkbox"/> Colistimethate |
| <input type="checkbox"/> Ciprofloxacin | <input type="checkbox"/> Penicillin G |
| <input type="checkbox"/> Meropenem | <input type="checkbox"/> Ampicillin |
| <input type="checkbox"/> Imipenem/Cilastatin | <input type="checkbox"/> Piperacillin/Tazobactam |
| <input type="checkbox"/> Ertapenem | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> CefTAZidime | |

Dose: _____
Frequency:
 q24h q12h q8h q6h q4h **Other** _____
Duration of remaining in-home treatment:
 _____ Days OR _____ Doses
Last Dose in Hospital:
 Date: _____ Time: _____
First Dose in Home:
 Date: _____ Time: _____

Not Covered by Ontario Drug Benefit:

- | | |
|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Levofloxacin | <input type="checkbox"/> Azithromycin |
| <input type="checkbox"/> Moxifloxacin | <input type="checkbox"/> Cefotaxime |
| <input type="checkbox"/> Erythromycin | |

***Community Vancomycin Therapy requires a Central Line due to the risk of Infiltration & Extravasation
 (If treatment is greater than 7 days).**

****If Drug Levels are required, ordering physician must complete a requisitions and direct patient to appropriate lab.**

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CCAC Home Infusion Parenteral Medication Form

HYDRATION ORDERS

Normal Saline – 0.9 % Sodium Chloride x 1 L Other hydration solutions: _____

Route: IV Subcutaneous

Duration of In-Home Treatment:

Rate: _____ mL over _____ Hours

_____ Days OR _____ Doses

Frequency: _____

Special Instructions: _____

Other Hydrations available include:

Potassium Chloride 20 meq.l in Normal Saline, Lactated Ringers, Dextrose 5% and 0.45% Sodium Chloride, Dextrose 5% and 0.9% Sodium Chloride and Dextrose 3.3% and 0.3% Sodium Chloride.

STANDARD FLUSH PROTOCOL

**** This standard Flush Protocol is for ADULTS only. MD/NP must complete specific flush protocol below for any paediatric clients on IV therapy.**

Catheter	Type of pm Adaptor	Pre-Infusion Flush	Post-Infusion Flush	Maintenance Flush	Pre and Post Blood Drawing	Pre and Post Intermittent TPN	Flushing Protocol for Continuous Infusion Pumps
Peripheral	Positive Pressure Device [PPD]*	3 cc NS	3 cc NS	3 cc NS q 24 hours			Change site q72 hours
Ex-Dwell/Midline	PPD	10 cc NS	10 cc NS	10 cc NS q 24 hours			Flush with 10 cc NS with each tubing change
Tunneled Catheter (ex. Hickman)	PPD	10 cc NS	10 cc NS	10 cc NS Weekly	Pre: 20 cc NS Post: 20 cc NS	Pre: 20 cc NS Post: 20 cc NS	Flush with 10 cc NS with each tubing change
Valved PICC Line (ex. Groshong)	PPD	10 cc NS	10 cc NS	10 cc NS Weekly	Pre: 20 cc NS Post: 20 cc NS	Pre: 20 cc NS Post: 20 cc NS	Flush with 10 cc NS with each tubing change
Open-ended PICC Line (not Groshong)	PPD	10 cc NS	10 cc NS	10 cc NS Weekly	Pre: 20 cc NS Post: 20 cc NS	Pre: 20 cc NS Post: 20 cc NS	Flush with 10 cc NS with each tubing change
Implanted Port	N/A	10 cc NS	10 cc NS followed by 5 cc 100 U/ml heparin	10 cc NS followed by 5 cc 100 U/ml heparin q 4 weeks	Pre: 20 cc NS Post: 20 cc NS followed by 5 cc 100 U/ml heparin	Pre: 20 cc NS Post: 20 cc NS followed by 5 cc 100 U/ml heparin	Flush with 10 cc NS with each tubing change

SPECIFIC FLUSH PROTOCOL

Specify: _____

Other Comments:

To consult a community Pharmacist with medication questions call
 Yurek Specialties Limited Phone: 519-680-2416 ext. 405 or 1-888-637-3690

Physician (PLEASE PRINT CLEARLY):

Name:	CPSO #:
Address:	Cell:
Telephone:	Pager:
Date:	Signature: