Ontario

Name
Health Card Number
D.O.B.
Address

IV THERAPY/VENOUS ACCESS MANAGEMENT MEDICAL ORDERS

Clear Form

Section 1 ROUTE

Diagnosis_____

☐ **(1) Peripheral IV**

PICC insertion pending – move to PICC directive below once insertion complete ☐

☐ **(2) Peripherally Inserted Central Catheter (PICC)**

Confirmed Catheter Tip Location: S.V.C. ☐ Other ☐ Catheter length: internal_____ external_____

PEDIATRIC Power PICC - Flush with _____ mL 0.9% sodium chloride IV followed by _____ mL of 100u/mL Heparin.

☐ **(3) Tunneled Central Venous Access Device** e.g. Hickman

☐ **(4) Implanted Central Venous Access Device** e.g. Port-a-Cath

ALLERGIES: ☐ Yes *(please list)* or ☐ No

In the event of Anaphylaxis, community nursing service providers will follow their specific agency policy.

Section 2 Medication Prescription **No other prescription req'd**

Drug _____ Dosage _____ Frequency _____ Stop/Reassess Date _____

Drug _____ Dosage _____ Frequency _____ Stop/Reassess Date _____

☐ **First dose infusion** to be given in community (see First Dose Parenteral Medication Screener)
Is this patient currently receiving beta blockers or ace inhibitor medication? ☐ Yes or ☐ No
*If Yes, patient is **not** eligible to receive first dose infusions in the community*

OR

Date and time of last dose in hospital _____

Mainline Intravenous solution (if applicable) 0.9% sodium chloride prn
All home/clinic IV antibiotic patients must see a physician weekly.

Bloodwork may be drawn by community nurse if central venous access device present. If no CVAD present, patient will be required to attend outpt lab. MD/NP must provide OHIP lab requisition.
☐ Requisition attached or ☐ Given to patient

For all IV antibiotic orders – weekly CBC, diff, creat, ALT, AST ☐ Yes ☐ No
For Vancomycin – weekly trough level, CBC, diff, creat ☐ Yes ☐ No
For Aminoglycosides – weekly trough and peak; twice weekly creat level ☐ Yes ☐ No

Refer to Aminoglycoside/Vancomycin Referral Serum Monitoring Guide

Section 3 MEDICAL RESPONSIBILITY

Transferred Medical Responsibility in the community will be to: Dr. _____
who has been made aware ☐ **Referring Physician Initials:** _____

Physician (print) _____ **Date** (dd/mm/yr) _____

Signature _____ **CPSO#** _____ Tel#: _____

**** Fax completed infusion orders with Home & Community Care referral form to 1 866 839 7299****

All infusion orders above will be executed as per Home and Community Care Support Services South East protocols documented on reverse side unless otherwise requested by referring MD/NP.

Print

Send both Page 1 and Page 2 with the community protocols to Home & Community Care

Revised April 2021

COMMUNITY PROTOCOLS APPLICABLE TO ALL ORDERS INDICATED ON FRONT PAGE UNLESS OTHERWISE STATED

The community protocols below are based on Best Practice. It is the responsibility of the referral source to specify if another protocol is required.

- ***C & S of IV site will be done if infection but only after obtaining requisition and swab needed from Lab.***
- ***Protocol references to Normal Saline are for sterile injectable NS unless otherwise indicated.***

1. Peripheral IV

Flush each time IV catheter is accessed and q 24 hours if IV catheter is not accessed with 3ml of 0.9% normal saline. Change site when clinically indicated or per community nursing agency protocol.

2. Peripherally Inserted Central catheter (PICC)

Initial dressing change within 48 hours after insertion, then q7days & prn.
Flush each lumen weekly & prn with 20mL of 0.9% sodium chloride.
If positive/neutral pressure device is used (maxplus), no heparin required. If no positive pressure device then flush is followed by 3mL of100u/mL Heparin lock flush.

3. Tunneled Central Venous Access Device ex. Hickman

Initial dressing change within 48 hours after insertion, then q7days & prn.
Flush each lumen weekly & prn with 10mL of 0.9% sodium chloride.
If positive/neutral pressure device is used (maxplus), no heparin required. If no positive pressure device then flush is followed by 3mL of100u/mL Heparin lock flush.

4. Implanted Central Venous Access Device (Port)

Initial dressing change within 48hrs after insertion. Frequency of flushing: monthly & prn. Flush each lumen with 10 mL of normal saline followed by 5 mL of 100u/mL HEPARIN Lock Flush.

Eligibility Criteria for First Dose Infusion in the Community: (must meet all criteria)

1. Patient does not have any serious allergies/adverse/anaphylactic reactions to the ordered medication or related drugs, and does not have a history of asthma, rhinitis, dermatitis or rash related to any allergen, including food.
2. The medication is not: iron, gold, amphotericin B, vancomycin, gancyclovir, bisphosphonates, furosemide, magnesium, potassium, anti-neoplastic or an investigational drug.
3. The patient is not on beta blocker or ace-inhibitor medication.
4. The patient is at least 1 year old and weighs at least 10 kg.
5. The patient has a working telephone.
6. There will be a most responsible person available to remain in the home for 4 hours post completion of medication administration.
7. Hospital emergency department is within 30 minutes.
8. Risks of having the first dose in the home has been explained to the patient/most responsible person and the patient/most responsible person has given consent.
9. The signs and symptoms of anaphylactic reaction have been explained to the patient.

For help to complete the form, please call the Home and Community Care Support Services South East Central Access Team at **1-800-869-8828 ext. 4289**.

NOTE: REFERRAL PROCESSING CANNOT BE INITIATED UNLESS PAGE 1 OF FORM IS COMPLETE. REFERRING PHYSICIAN WILL BE NOTIFIED RE MISSING & REQUIRED INFORMATION AS SOON AS NOTED, IN ORDER TO PREVENT DELAY IN SERVICE ARRANGEMENTS.