First Dose Intravenous Therapy in the Community Risk Assessment Form

Contact the **HCCSS** HNHB at 1-800-810-0000 Fax completed copy to 1-866-655-6402

Patient Name _____ HCN _____ VC _____ DOB _____

Address _____ City _____ Province _____ Postal Code _____

Patient Phone _____ Contact Name _____ Contact Phone _____

PART 1: Patient is eligible for first dose IV in the community without further assessment if they meet one of the following reasons below (IF ELIGIBLE - NO NEED TO COMPLETE PART 2).

Select reason for eligibility and complete medical orders:

- ☐ Medication is pre-approved for first dose (dexamethasone, dimenhydrinate, diphenhydramine, magnesium, octreotide, potassium chloride, potassium phosphate, pantoprazole, ranitidine, vancomycin, ferric derisomaltose (FD))
- ☐ Patient resides in a Long-Term Care Home
- ☐ Patient has no prior history of allergy to medication in the same class that is being prescribed

If patient does not meet any reason listed above for eligibility, proceed to Part 2

PART 2: Only complete if patient NOT eligible in Part 1

First Dose Risk Assessment – Must answer YES to all questions to be eligible to receive the first dose in the community setting:

	Yes	No
1. Patient does not have any serious allergies, adverse reactions or anaphylactic reactions to the ordered medication, related drugs or unknown origin.	☐	☐
2. The signs and symptoms of anaphylactic reaction have been explained to the patient or caregiver.	☐	☐
3. The medication is not: Amikacin, Amphotericin Deoxycholate, Antineoplastic, Colistin, Gentamycin, Gold Therapy, Investigational, Iron Sucrose, or Tobramycin.	☐	☐
4. The patient is not on a beta blocker.	☐	☐
5. The patient is at least 1 year old and weighs at least 10 kg.	☐	☐
6. The patient has a working telephone.	☐	☐
7. There is a capable adult (18 years or older) available to remain in the home for 6 hours post completion of medication administration.	☐	☐
8. Hospital emergency department is within 30 minutes of where first dose would be administered.	☐	☐

☐ I have explained the risks of having the first dose in the community to the patient/ substitute decision maker and the patient/substitute decision maker has given verbal consent.

Practitioner (MD/NP) Completing the Risk Assessment Form:

Name _____ CPSO/CNO Reg.# _____

Phone _____ Backline or Cell _____ Fax _____

Signature: _____ Date: _____

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Ontario