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Medical Orders - Parenteral Therapy

Primary Diagnosis _____

Sex M F Height _____ Weight _____

Serum Creatinine _____ Date _____

Surgical Procedure & Date _____	Allergies _____
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VENOUS ACCESS INFORMATION / FLUSH INSTRUCTIONS / DRESSING CHANGES (Physician, RN or LHIN to complete)

- Saline Lock Midline PICC Valved Open Ended Tunnelled
 Implanted Port Non-Accessed Accessed Active Inactive

Size of Gripper Needle _____ g x _____ in Length of Catheter Internal _____ cm External _____ cm

Date of Insertion _____ Size of Catheter _____ Gauge _____ Number of Lumens _____

- Flush line and change dressing as per: Community Protocol WW144 Hospital Protocol (please attach)

Special Instructions:

BLOOD WORK Is bloodwork required? Yes No Freq _____ Start Date _____ Nurse to draw from central line

Has physician completed MOHLTC lab requisition? Yes No *Required for Vancomycin (see P&P 8.1.7)

MEDICATION / SOLUTION ORDER (Physician must complete)

Drug _____ Dose _____

Frequency / Rate _____

Has first dose been given Yes No Route: SC IM IV

First Dose Date / Time _____

Start Date _____ Time _____ LU # _____

Stop Date _____ Time _____ OR # of Days _____

MEDICATION / SOLUTION ORDER (Physician must complete)

Drug _____ Dose _____

Frequency / Rate _____

Has first dose been given Yes No Route: SC IM IV

First Dose Date / Time _____

Start Date _____ Time _____ LU # _____

Stop Date _____ Time _____ OR # of Days _____

MEDICATION ORDER FOR PAIN AND SYMPTOM MANAGEMENT PUMP (Physician must complete)

Pharmacist Contact Information _____ Phone # 1-844-607-6362 at Bayshore Specialty Rx

Drug: _____ Route: SC IV

Conc: _____ mg/ml Basal Rate _____ mg/hr Bolus _____ mg q _____ Minutes

Total Quantity _____ x 50ml 100ml 250ml 500ml Containers Dispense _____ Containers q _____ Days PRN

PROVISION FOR MISSED DOSE (Physician must complete) Client may miss one dose Contact physician for specific orders

Backup Emergency Order Drug _____ Route: S/C IM

Directions _____ Quantity (24hr coverage) _____ Bayshore Rx to supply Y N

PRESCRIBER INFORMATION - I have explained the benefits and risks of parenteral therapy in the home:

Name (print) _____ MD NP RN(EC) Phone # (private) _____

Signature _____ Date _____ CPSO/CNO# _____

Care Coordinator _____ Phone _____ Ext. _____