

Name:			
Address:		Postal Code:	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> undifferentiated <input type="checkbox"/> unknown		Date of Birth:	
HCN (mandatory):		Phone:	
Primary Diagnosis:		Version Code:	
Other Diagnosis Pertinent to Care:			
Height:	Weight:	Blood Pressure:	Diabetic: <input type="checkbox"/> Yes <input type="checkbox"/> No
Telehomecare: <input type="checkbox"/> Yes <input type="checkbox"/> No		Related to: <input type="checkbox"/> COPD <input type="checkbox"/> CHF	
IF CANCER DIAGNOSIS OR A LIFE LIMITING ILLNESS			
Metastatic Spread: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Describe:			
Ongoing Treatment: <input type="checkbox"/> Palliative <input type="checkbox"/> Curative			
Anticipated Prognosis: <input type="checkbox"/> 0 <6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> Uncertain			
LINE TYPE			
<input type="checkbox"/> Peripheral <input type="checkbox"/> Midline <input type="checkbox"/> PICC <input type="checkbox"/> Hickman <input type="checkbox"/> Port <input type="checkbox"/> SC			
Insertion date:		# of lumen(s):	
Allergies:			
IV MEDICATIONS/ HYDRATION			
Alternative routes discussed <input type="checkbox"/> Yes <input type="checkbox"/> No			
1st Dose Given: <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES , indicate date and time given:			
1st Community Dose: indicate date and time:			
Name of Medication:		Dosage:	Route:
Frequency:	# of Doses Required:	# of Days of therapy in Community:	
Name of Medication:		Dosage:	Route:
Frequency:	# of Doses Required:	# of Days of therapy in Community:	
For hydration, specify reason:			
SPECIFIC PHYSICIAN ORDERS: (PLEASE STATE)			
• Infusion/dressing protocols per line type			
• Saline Flush: _____ or _____ per nursing agency protocol			
• Heparin Flush – specific Physician/Nurse Practitioner order required:			
• Specify lab orders if required:			
• Other treatment/therapies/services:			
Note: If unable to restart – send patient to Emergency Department. Loss of IV site may result in a missed dosage of medication			
Unless otherwise indicated, Ontario Health atHome may determine frequency of visits, arrange for teaching of patient/caregiver(s)/other regulated staff/reliable person(s).			

Hospital Fax Lines
<input type="checkbox"/> Campbellford Memorial Hospital Fax: 1-844-631-5800
<input type="checkbox"/> Haliburton Highlands Health Services Fax: 1-844-709-3779
<input type="checkbox"/> Northumberland Hills Hospital Fax: 1-844-631-5801
<input type="checkbox"/> Lakeridge Health Ajax Pickering Fax: 905-444-2524
<input type="checkbox"/> Lakeridge Health Bowmanville Fax: 1-844-631-5802
<input type="checkbox"/> Lakeridge Health Oshawa Fax: 905-444-2516
<input type="checkbox"/> Lakeridge Health Port Perry Fax: 1-844-631-5803
<input type="checkbox"/> Lakeridge Health Whitby Fax: 905-444-2518
<input type="checkbox"/> Ontario Shores Fax: 1-844-631-5803
<input type="checkbox"/> Markham Stouffville Uxbridge Site Fax: 1-844-631-5803
<input type="checkbox"/> Peterborough Regional Health Centre Fax: 1-855-444-9628
<input type="checkbox"/> Scarborough and Rouge Hospital – Birchmount Site Fax: 1-844-631-5804
<input type="checkbox"/> Scarborough and Rouge Hospital – General Campus Fax: 1-844-631-5805
<input type="checkbox"/> Scarborough and Rouge Hospital – Centenary Site Fax: 1-844-631-5808
<input type="checkbox"/> Ross Memorial Hospital Fax: 1-844-631-5806

ORDERING PHYSICIAN/NURSE PRACTITIONER	
CPSO/ CNO#:	Print Name:
Signature:	Date:

CONTACT INFORMATION FOR ORDERING PHYSICIAN	
Phone:	Fax:
After Hours:	
LAB RESULTS TO BE SENT TO	
Physician/Nurse Practitioner Name:	Fax: