HOME AND COMMUNITY CARE SUPPORT SERVICES
South West

SERVICES DE SOUTIEN À DOMICILE ET EN MILIEU COMMUNAUTAIRE
Sud-Ouest

Adult Parenteral Antibiotic Therapy Order

356 Oxford Street West London, ON N6H 1T3
Telephone: 1-800-811-5146 Fax: 519-472-4045

Patient Information

Surname	First Name		
Delivery Address			
City	Postal Code	Direct Telephone Number	
Health Card Number (HCN)	Version Code	Date of Birth (YYYY-Month-DD)	Assigned Sex at Birth ○ Male ○ Female

Gender Identity
○ Male ○ Female ○ Non-Binary ○ Transgender Female ○ Transgender Male ○ Gender Variant/Non-conforming ○ Not disclosed ○ Not Listed

Alternate Contact Name	Relationship to Patient	Telephone Number

Orders are processed between 8 am– 8pm, 7days/week and require a minimum 4-hour turn around window.
HCCSS South West uses a Clinic First Approach to service delivery.

Medical Information

Height	Weight	Drug Allergies (list ALL)

☐ No known drug allergies

Medication Delivery Access
○ Intravenous *(Vascular Access details must be completed)* ○ Intramuscular ○ Intraperitoneal

Vascular Access Details (required for intravenous infusions)
○ Vascular access in place Date Inserted (YYYY-Month-DD): _____ Needle Gauge/Size: _____
○ Peripheral Line ○ Midline ○ Implanted Port ○ Central Line / Peripherally Inserted Central Catheter (PICC)
Number of lumens: _____ Inserted length: _____ cm ☐ Position confirmed on chest x-ray
○ Peripheral vascular access to be started in community

Lab Investigations, if available (Serum creatinine required for drug level monitoring)
Last serum creatinine: _____ µmol/L OR eGFR _____ Date of sample: _____

Vascular Access Management Instructions
○ Remove vascular access after treatment completed ○ Continue flush protocol until further instructed
○ Other: _____ Lab Request completed and given to patient ☐

Flush/Lock Protocol

○ Use standard flush protocol (see appendix below)
○ Use other flush protocol (please specify):
_____

Dressing Change Instructions

○ Service provider to follow best practice
○ Other dressing change instructions:
_____

Antibiotic Prescription

Clinical Indication for Antibiotic Use
☐ Cellulitis ☐ Pneumonia ☐ Urinary Tract Infection ☐ Osteomyelitis ☐ Intra-abdominal infection ☐ Bloodstream/Septicemia
☐ Other: _____

Antibiotic Selection (one antibiotic/form)

◆ Renal dosing required ● Drug level monitoring required

○ Ampicillin ◆
○ CeFAZolin ◆
○ CefTAZidime ◆
○ CefTRIAXone
○ Cloxacillin
○ Penicillin G
○ Piperacillin / Tazobactam ◆
○ Vancomycin ◆● (central line required for treatment > 7 days)

Protected Antibiotics

☐ This request underwent Infectious Diseases (ID) Specialist review.
If no ID involvement, Community Pharmacist will review within 72 hours.

○ Ciprofloxacin ◆
○ Meropenem ◆
○ Imipenem ◆
○ Ertapenem ◆
○ Gentamicin ◆●
○ Tobramycin ◆●
○ Other:
_____

Ontario

Surname	First Name	HCN

Antibiotic Prescription continued

Dosage	Frequency
	◯ Q24H ◯ Q12H ◯ Q8H ◯ Q6H ◯ Q4H ◯ Other: _____

Date of Last Dose in Hospital – (YYYY-Month-DD)	Time of Last Dose in Hospital
	◯ am ◯ pm ◯ N/A

FIRST DOSE: If first dose is required in the Community Nursing Clinic, prescriber to fill the South West IV First Dose and Iron Sucrose Screener with this referral: **https://healthcareathome.ca/document/south-west-iv-first-dose-and-iron-sucrose-screener/**

Community Therapy Start Date – (YYYY-Month-DD)	Start Time	Duration of Community Treatment	End Date – (YYYY-Month-DD)
	◯ am ◯ pm ☐ Start time can be delayed up to 8 hours	◯ days ◯ doses	

NOTE: Delayed start is recommended when start time falls between 8pm and 8am.

Special Instructions

To consult a Community Pharmacist
Yurek's Specialties Limited (London, Middlesex, Oxford, Elgin & South Huron) - Phone: 1-519-680-7474, Ext: 5404
Brown's Pharmacy (Grey Bruce, North Huron/Perth) - Phone: 1-519-881-2420 or 1-844-474-7577

Referrer Details

Referrer Name and Designation	CPSO/CNO/RCDSO Registration	OHIP Billing Number

Phone Number	Fax Number

Office Address

City	Postal Code

Referrer Signature	Date Signed (YYYY-Month-DD)

Complete and fax to Home & Community Care Support Services South West at 1-519-472-4045 or 1-855-223-2847
Referral form must be completed in full to permit processing. Incomplete orders will be returned

Appendix

Flush/Lock Protocol

	Pre- & Post-Infusion	Maintenance Flush (Inactive Line)	Pre- & Post-Intermittent TPN
Peripheral	3-5mL Normal Saline (N/S)	3-5 mL N/S Q24H	
Midline	10mL N/S	10mL N/S Q24H	
Central Line/PICC	10-20mL N/S	10-20mL N/S Q24H	10-20 mL N/S
Implanted Port	10-20mL N/S	10-20mL N/S every 4 weeks (*)	10-20 mL N/S (*)

NOTE: Community Nurses will use their clinical judgement to flush central lines with fluid volumes between 10mL - 20mL considering the type/size of catheter, patient profile and type of infusion therapy. All Central Venous Catheter line kits deployed to HCCSS South West patients consist of two 10 mL NS syringes to complete "Push-Pause" technique to the lines' port located closest to the patient.

Surname	First Name	HCN

Antibiotic Stewardship Community Prescribing Best Practice Guidelines

Consider transitioning to oral antibiotics as soon as able. Do not use this form to order oral medications.

Infection Source	Recommended (IV)	Secondary Antibiotic (IV)	Duration	Oral (PO) Transition
Cellulitis / Bursitis	Cefazolin 1-2g q8h	Ceftriaxone 1-2g q24h	5-7 days	• Cephalexin * 500mg QID • Cefadroxil 500-1000mg BID • Amoxicillin–clavulanate * 500mg TID • Amoxicillin–clavulanate * 875mg BID • Trimethoprim-sulfamethoxazole 1 DS BID (major penicillin allergy or MRSA) • Clindamycin 150-300mg QID (major penicillin allergy or MRSA • Doxycycline 100mg BID (major penicillin allergy or MRSA)
Pneumonia	Ceftriaxone 1-2g q24h		5-7 days	• Amoxicillin-clavulanate * 500mg TID • Amoxicillin–clavulanate * 875mg BID • Cefuroxime * 500mg BID • Azithromycin 500mg on day 1, then 250mg daily x 4 days (major penicillin allergy) • LevoFLOXacin * 500mg daily (major penicillin allergy) • Doxycycline 100mg BID (major penicillin allergy)
Urinary Tract Infection	Ceftriaxone 1-2g q24h		3-5 days (cystitis); 7-14 days (pyelonephritis)	• Amoxicillin-clavulanate * 500mg TID • Amoxicillin–clavulanate * 875mg BID • Sulfamethoxazole-trimethoprim 1 DS BID • Ciprofloxacin 500mg BID (major penicillin allergy) • Nitrofurantoin 100mg BID (cystitis only) • Fosfomycin 3g once (cystitis only)
Osteomyelitis	Cefazolin 2g q8h	1. Cloxacillin 2g q4-6h (staphylococcal osteomyelitis) 2. Vancomycin 1g q12h (major penicillin allergy or MRSA infection) 3. Piperacillin/tazobactam 4.5g q6h (polymicrobial infection or infection in diabetic patient)	6 weeks	• Cephalexin 500mg PO QID or 1000mg TID (staphylococcal osteomyelitis) • Amoxicillin-clavulanate * 500mg TID (polymicrobial or diabetic foot infection) • Amoxicillin–clavulanate * 875mg BID • Cefadroxil 500-1000mg BID • Doxycycline 100mg BID (major penicillin allergy or MRSA)
Intra-abdominal Infection	Ceftriaxone 1-2g q24h (in combination with PO metronidazole 500mg BID)	Piperacillin/tazobactam 4.5g q8h	5-14 days (depending on source and severity)	• Amoxicillin-clavulanate * 500mg TID • Ciprofloxacin 500mg BID plus metronidazole 500mg BID (major penicillin allergy)
Bloodstream Infection / Bacteremia / Septicemia	**Staphylococcus aureus / Group A or B or C Streptococcus** Cefazolin 1-2-g q8h **OR** Cloxacillin 2g q4-6h **OR** Vancomycin 1g q12h (major penicillin allergy or MRSA infection)	**Streptococcus pneumoniae** 1. Ceftriaxone 1-2g q24h 2. Penicillin G 3-4 million unit q4h **E. coli/Klebsiella/Proteus** 1. Cefazolin 1-2g q8h 2. Ceftriaxone 1-2g q24h **Pseudomonas** 1. Piperacillin/tazobactam 4.5g q6h 2. Ceftazidime 1-2g q8h 3. Meropenem 1-2g q8h (for drug-resistant strains)	1-2 weeks (minimum 2 weeks for Staphylococcus aureus bacteremia or other complicated bacteremia)	**Streptococcus pneumoniae** • LevoFLOXacin * 500mg q24h (major penicillin allergy) • Amoxicillin–clavulanate * 500mg TID • Amoxicillin–clavulanate * 875mg BID **E. coli/Klebsiella/Proteus** • LevoFLOXacin 500mg q24h (major penicillin allergy) • Amoxicillin–clavulanate * 500mg TID