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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)

**COVID 19 THERAPEUTICS- Please attach current medication list.**

Patient qualifies for Remdesivir treatment as per Science Table guidelines. (If patient does not qualify, an alternative treatment will be sourced)

Remdesivir -200 mg IV on Day 1, 100 mg IV daily on days 2 and 3 Date of symptom onset: \_\_\_\_\_

Is patient on beta blockers?  Yes  No

Please note initial dose could may be delayed by next business day if referral received with insufficient processing time.

**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. \_\_\_\_\_