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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 Ontario Health guidelines. (If patient does not qualify, an alternative treatment will be  
 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 If yes, does the benefit of Remdesivir outweigh the risk?  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. \_\_\_\_\_