

Addressograph or Label

Confirmed Discharge Date: _____		or within: <input type="checkbox"/> 24 hrs <input type="checkbox"/> 48 hrs <input type="checkbox"/> 72 hrs <input type="checkbox"/> Other		
Diagnosis:	Allergies:	Precautions: <input type="checkbox"/> Contact <input type="checkbox"/> Droplet/Contact <input type="checkbox"/> Droplet <input type="checkbox"/> Airborne		
		Reason for isolation:		
Prognosis (i.e. Months):		Discussed Care Plan with Patient/Caregiver <input type="checkbox"/> Yes <input type="checkbox"/> No		
		Discussed Care Plan with Primary Care Provider <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
Palliative Performance Scale (0-100%): % <input type="checkbox"/> Improve <input type="checkbox"/> Remain Stable <input type="checkbox"/> Maintenance <input type="checkbox"/> Deteriorate				
Service Requested		<i>Note: Eligible patients will receive nursing services within a clinic setting</i>		
Nursing: Wound Care				
As per Integrated Wound Care Pathways				
<input type="checkbox"/> Pilonidal Sinus	<input type="checkbox"/> Diabetic Foot Ulcer	<input type="checkbox"/> Pressure Injury (Stage _____)	<input type="checkbox"/> Maintenance/Chronic Arterial Ulcer	
<input type="checkbox"/> Venous leg Ulcer	<input type="checkbox"/> Surgical Acute	<input type="checkbox"/> Lymphedema	<input type="checkbox"/> Non-Complex Burn Skin Tear	
<input type="checkbox"/> Cellulitis	<input type="checkbox"/> Surgical Chronic	<input type="checkbox"/> Trauma	<input type="checkbox"/> Other: _____	
Compression Therapy for VIU - requires recent measurements: (ABPI) _____ Date: _____				
NOTE: Wound care products may be substituted with a comparable product based on Home and Community Care Support Services Central West supply list. Other - refer to Additional Orders				
<input type="checkbox"/> Nursing: Specialty	<input type="checkbox"/> Rapid Response Nurse <input type="checkbox"/> NP-Palliative - Reason for Referral to NP: _____			
<input type="checkbox"/> Nursing: General	<input type="checkbox"/> Ostomy Care/teaching <input type="checkbox"/> Drain Care/Teaching <input type="checkbox"/> Catheter Care/Teaching <input type="checkbox"/> Enteral Feed <input type="checkbox"/> Palliative Care <input type="checkbox"/> Symptom Management <input type="checkbox"/> Other: _____			
ADDITIONAL ORDERS (attach additional information as needed):				
<input type="checkbox"/> Nursing: IV Medication #1	Drug	Dose	Route	Frequency
	Duration	First dose given in hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No	*Time of administered last dose:	
<input type="checkbox"/> Nursing: IV Medication #2	Drug	Dose	Route	Frequency
	Duration	First dose given in hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No	*Time of administered last dose:	
COVID-19 Therapeutics (Remdesivir)	<input type="checkbox"/> Patient qualifies for REMDESIVIR treatment as per science table guidelines Date of COVID-19 symptom onset: _____ <input type="checkbox"/> Remdesivir - 200 mg IV on Day 1, 100 mg IV daily on days 2 and 3 Is patient on beta-blockers? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, does the benefit of Remdesivir treatment outweigh risk? Yes <input type="checkbox"/> No <input type="checkbox"/> Is this a first dose? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, Dose 1 date _____ ; Dose 2 date _____			
<input type="checkbox"/> Nursing: IV Hydration	Solution: _____ Rate: _____ Duration: _____ Start: _____			
<input type="checkbox"/> Nursing: Central Lines (Adults)	<input type="checkbox"/> PICC line flush orders: Flush and lock each lumen with 10 ml NaCl 0.9% post infusion, weekly and PRN. Insertion Date: _____ <input type="checkbox"/> Central venous line dressing orders: Cleanse site with chlorhexidine and apply op-site weekly and PRN, change cap weekly. <input type="checkbox"/> Port-a-Cath care orders: Flush and lock port-a-cath with 10 ml NaCl 0.9%. Flush q 1 month when not in use using a non-coring needle. <input type="checkbox"/> Tunneled catheter (e.g. Hickman) flush orders: Flush and lock each lumen with 10 ml NaCl 0.9% weekly.			
<input type="checkbox"/> Additional Recommendations (e.g. OT, PT, Pharmacy Consult, etc.) Weight bearing status: *Note: Eligibility and availability to be assessed and determined by a Home and Community Care Support Services Central West Care Coordinator (attach additional information as needed).				
Patient has been informed to follow up with their Primary Care Provider: <input type="checkbox"/> Yes, within _____ days <input type="checkbox"/> No <input type="checkbox"/> N/A				
Referring Physician/Nurse Practitioner/Other		OHIP Billing #		
Name (Print):	Signature: _____	_____		
Designation:	Telephone: _____	DD/MM/YY		