

Medical Orders - Parenteral Therapy

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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)

<input type="checkbox"/> Saline Lock	<input type="checkbox"/> Midline	<input type="checkbox"/> PICC	<input type="checkbox"/> Valved	<input type="checkbox"/> Open Ended	<input type="checkbox"/> Tunnelled
<input type="checkbox"/> Implanted Port	<input type="checkbox"/> Non-Accessed	<input type="checkbox"/> Accessed	<input type="checkbox"/> Active	<input type="checkbox"/> 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 _____

<input type="checkbox"/> Flush line and change dressing as per:	<input type="checkbox"/> Community Protocol WW144	<input type="checkbox"/> Hospital Protocol (please attach)
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 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 [COVID-19 Treatment | Ontario Health](#)

Remdesivir - 200 mg IV on Day 1, 100 mg IV 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 <input type="checkbox"/> Yes <input type="checkbox"/> No Route: <input type="checkbox"/> SC <input type="checkbox"/> IM <input type="checkbox"/> IV
First Dose Date / Time _____
Start Date _____ Time _____ LU # _____
Stop Date _____ Time _____ OR # of Days _____

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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. _____