Infusion Therapy Referral Form

Phone: 800-263-3877 Fax: 855-352-2555

Name:			
Address:			**Postal Code:**
Sex: ☐ **M** ☐ **F**	**Date of Birth:**		**Phone:**
HCN (mandatory):			**Version Code:**
Height:	Weight:	Blood Pressure:	Diabetic: ☐Yes ☐ No
Primary Diagnosis:			
Other Diagnosis Pertinent to Care:			
If your patient is in hospital please indicate hospital site:			
Allergies:			
Telehomecare: ☐Yes ☐No	Related to: ☐COPD ☐CHF		

IF CANCER DIAGNOSIS OR A LIFE LIMITING ILLNESS

Metastatic Spread: ☐ Yes ☐ No ☐ Describe:

Ongoing Treatment: ☐ Palliative ☐ Curative

Anticipated Prognosis: ☐ 0 <6 months ☐ 6-12 months ☐ Uncertain

LINE TYPE

☐Peripheral ☐Midline ☐PICC ☐Hickman ☐Port ☐ SC

Insertion date: # of lumen(s):

IV MEDICATIONS/ HYDRATION

Alternative routes discussed ☐ Yes ☐ No

1st Dose Given: ☐ Yes ☐ No **IF YES**, indicate date and time given:

1st Community Dose: indicate date and time:

Name of Medication:	Dosage:	Route:
Frequency:	# of Doses Required:	# of Days of therapy in Community:
Name of Medication:	Dosage:	Route:
Frequency:	# of Doses Required:	# of Days of therapy in Community:

For hydration, specify reason:

SPECIFIC PHYSICIAN ORDERS: *(PLEASE STATE)*

- Infusion/dressing protocols per line type
- Saline Flush: or per nursing agency protocol
- Heparin Flush – specific Physician/Nurse Practitioner order required:
- Specify lab orders if required:
- Other treatment/therapies/services:

Note: If unable to restart – send patient to Emergency Department. Loss of IV site may result in a missed dosage of medication

Unless otherwise indicated, the Local Health Integration Network may determine frequency of visits, arrange for teaching of patient/ caregiver(s)/other regulated staff/reliable person(s).

ORDERING PHYSICIAN/NURSE PRACTITIONER

CPSO/ CNO#: Print Name:

Signature: Date:

CONTACT INFORMATION FOR ORDERING PHYSICIAN

Phone: Fax:

After Hours:

LAB RESULTS TO BE SENT TO

Physician/Nurse Practitioner Name: Fax:

Ontario
Central East Local Health Integration Network