Ontario
South West Local Health Integration Network
Réseau local d'intégration des services de santé du Sud-Ouest

# South West LHIN Home Infusion Parenteral Medication Form PHYSICIAN OR NP ORDERS

Fill out or add Addressograph Label

**Name:** ________________________________________

**Gender:** ______ **D.O.B.**(dd/mm/yyyy)**:** ___/____/_______

**HCN:** ________________________________________

**Address:** ________________________________________
________________________________________

**Phone Number:** ________________________________

***Contact information is critical for community IV service provision; Please Verify the Care Destination with the client.**
**Additional Contact Information:**________________________________________

**Please Complete and Fax both pages of this order form to:**
**South West LHIN 519-472-4045 or 1-855-223-2847**

**LINE:** □ Peripheral Line □ Central Line/Port

**LIST ALL Known Allergies:** ________________________________________

## ANTIBIOTIC SELECTION #1

□ Cefazolin
□ Ceftriaxone
□ Vancomycin* **
□ Metronidazole
□ Ciprofloxacin
□ Meropenem
□ Imipenem/Cilastatin
□ Ertapenem
□ CefTAZidime

□ Clindamycin
□ Gentamicin**
□ Tobramycin
□ Colistimethate
□ Penicillin G
□ Ampicillin
□ Piperacillin/Tazobactam
□Other____________________

**Not Covered by Ontario Drug Benefit:**

□ Levofloxacin
□ Moxifloxacin
□ Erythromycin
□ Azithromycin
□ Cefotaxime

**Dose**:________________

**Frequency**:
□ q24h □ q12h □ q8h □ q6h □ q4h **Other** _____

**Duration of remaining in-home treatment**:
________ Days OR _______ Doses

**Last Dose in Hospital:**
Date: ________________ Time: _________

**First Dose in Home:**
Date: ________________ Time: _________

## ANTIBIOTIC SELECTION #2

□ Cefazolin
□ Ceftriaxone
□ Vancomycin* **
□ Metronidazole
□ Ciprofloxacin
□ Meropenem
□ Imipenem/Cilastatin
□ Ertapenem
□ CefTAZidime

□ Clindamycin
□ Gentamicin**
□ Tobramycin
□ Colistimethate
□ Penicillin G
□ Ampicillin
□ Piperacillin/Tazobactam
□ Other___________________

**Not Covered by Ontario Drug Benefit:**

□ Levofloxacin
□ Moxifloxacin
□ Erythromycin
□ Azithromycin
□ Cefotaxime

**Dose**: ________________

**Frequency**:
□ q24h □ q12h □q8h □ q6h □ q4h **Other** _____

**Duration of remaining in-home treatment:**
________ Days OR _______ Doses

**Last Dose in Hospital:**
Date: ________________ Time: _________

**First Dose in Home:**
Date: ________________ Time: _________

***Community Vancomycin Therapy requires a Central Line due to the risk of Infiltration & Extravasation (If treatment is greater than 7 days).**

****If Drug Levels are required, ordering physician must complete a requisitions and direct patient to appropriate lab.**

Ontario
South West Local Health Integration Network
Réseau local d'intégration des services de santé du Sud-Ouest

# LHIN Home Infusion Parenteral Medication Form

Fill out or add Addressograph Label

**Name:** ______________________________

**Gender:** ______ **D.O.B.**(dd/mm/yyyy)**:** ___/____/_______

**HCN:** ______________________________

**Address:** ______________________________

______________________________

**Phone Number:** ______________________________

## HYDRATION ORDERS

□ Normal Saline – 0.9 % Sodium Chloride x 1 L □ Other hydration solutions: ______________________

**Route:** □ IV □ Subcutaneous

**Rate**: _________ mL *over* ________Hours

**Frequency:** ______________________

**Duration of In-Home Treatment:**

________ Days OR _______ Doses

**Special Instructions:** ______________________________

______________________________

**Other Hydrations available include:**

Potassium Chloride 20 meq.l in Normal Saline, Lactated Ringers, Dextrose 5% and 0.45% Sodium Chloride, Dextrose 5% and 0.9% Sodium Chloride and Dextrose 3.3% and 0.3% Sodium Chloride.

## STANDARD FLUSH PROTOCOL □

**** This standard Flush Protocol is for ADULTS only. MD/NP must complete specific flush protocol below for any paediatric clients on IV therapy.**

| Catheter | Type of pm Adaptor | Pre-Infusion Flush | Post-Infusion Flush | Maintenance Flush | Pre and Post Blood Drawing | Pre and Post Intermittent TPN | Flushing Protocol for Continuous Infusion Pumps |
|---|---|---|---|---|---|---|---|
| **Peripheral** | Positive Pressure Device [PPD]* | 3 cc NS | 3 cc NS | 3 cc NS q 24 hours | | | Change site q72 hours |
| **Ex-Dwell/Midline** | PPD | 10 cc NS | 10 cc NS | 10 cc NS q 24 hours | | | Flush with 10 cc NS with each tubing change |
| **Tunneled Catheter (ex. Hickman)** | PPD | 10 cc NS | 10 cc NS | 10 cc NS Weekly | Pre: 20 cc NS Post: 20 cc NS | Pre: 20 cc NS Post: 20 cc NS | Flush with 10 cc NS with each tubing change |
| **Valved PICC Line (ex. Groshong)** | PPD | 10 cc NS | 10 cc NS | 10 cc NS Weekly | Pre: 20 cc NS Post: 20 cc NS | Pre: 20 cc NS Post: 20 cc NS | Flush with 10 cc NS with each tubing change |
| **Open-ended PICC Line (not Groshong)** | PPD | 10 cc NS | 10 cc NS | 10 cc NS Weekly | Pre: 20 cc NS Post: 20 cc NS | Pre: 20 cc NS Post: 20 cc NS | Flush with 10 cc NS with each tubing change |
| **Implanted Port** | N/A | 10 cc NS | 10 cc NS followed by 5 cc 100 U/ml hepalean | 10 cc NS followed by 5 cc 100 U/ml hepalean q 4 weeks | Pre: 20 cc NS Post: 20 cc NS followed by 5 cc 100 U/ml hepalean | Pre: 20 cc NS Post: 20 cc NS followed by 5 cc 100 U/ml hepalean | Flush with 10 cc NS with each tubing change |

## SPECIFIC FLUSH PROTOCOL □

Specify:______________________________________________

______________________________________________

**Other Comments:**

**To consult a community Pharmacist with medication questions call**
**Yurek Specialties Limited Phone: 519-680-2416 ext. 405 or 1-888-637-3690**

**Physician (PLEASE PRINT CLEARLY):**

| | |
|---|---|
| **Name:** | **CPSO #:** |
| **Address:** | **Cell:** |
| **Telephone:** | **Pager:** |
| **Date:** | **Signature:** |