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Name ______________________
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City ______________ PC __________
Phone ______________ DOB __________ DD/MM/YY
HCN ______________ VC __________

# REFERRAL INFORMATION

## HOME INFUSION THERAPY

| | |
|---|---|
| Primary Diagnosis<br>Secondary Diagnosis | Statistical Information for Best Practice Dose Calculations by Pharmacist**:** |
| Surgical Procedure & Date | Age ____ Sex _____Ht.______ Wt _____ |
| Reason for Referral | Creatinine Clearance<br>Allergies |

### Service Request
(where feasible client/caregiver will be taught treatment protocol)

**Catheter Type & Information (Physician/RN to complete)**

☐ Saline Lock ☐ Midline ☐ PICC (Please check type) ____________
☐ Valved ☐ Open ended
☐ Extended Dwell ☐ Tunnelled (type) ____________
☐ Implanted Port ☐ Accessed: ☐ Active or ☐ Inactive
☐ Non-Accessed
Size of Gripper Needle ________ G x ________in
☐ Other ______________________________
Date of Insertion ____________________
Length of Catheter Internal__________cm
External __________cm
Size of catheter (gauge) ________ Number of Lumens____________

**Flush Instructions and Dressing Changes (Physician to complete)**

☐ Lines to be flushed and dressing changed as per "Community Nursing Protocols for Infusion Therapy Line Maintenance". For lines requiring Heparin Flush, Heparin 100u/ml.
Dressing Change due______________________
OR Special Instructions as follows:
Solution ____________________ Amount _______
Frequency of dressing change _________________
Additional Information ____________________________

**Pain Medication Order for Infusion Pump (Physician to complete)**

Pharmacist will formulate concentration **(Separate Rx required)**
Drug ______________________________
Basal Rate ___________ mg/hr
Bolus Dose ___________ mg every ____________ minutes
Additives (mg/24 hrs)

**IV Medication/Solution Order (Physician to complete)**

Drug ______________________________
Dose _________Frequency ___________ Rate ________
First Dose Date _______________ Time ____________
\# of days _____
Stop Date _________ Time _____________

**IV Medication/Solution Order (Physician to complete)**

Drug ______________________________
Dose_________Frequency ___________ Rate ________
First Dose Date_______________ Time ____________
\# of days _____
Stop Date __________________ Time__________

**IV Medication/Solution Order (Physician to complete)**

Drug ______________________________
Dose_________Frequency ___________ Rate________
First Dose Date_______________ Time ____________
\# of days_____
Stop Date __________________ Time____________

**Provision for Missed Dose (Physician to complete)**

In the event of inclement weather or difficulty with the device:
☐ Client may miss one dose
☐ Substitute oral dose (separate Rx required)

**Blood Work** **(Physician must order and arrange with Lab)**
Is blood work required? ☐ No ☐ Yes Frequency______ Start Date __________________
Physician has ordered lab work from ☐ MDS Labs (fax/phone) ☐ CML (fax/phone)
Visiting Nurse to draw from central line? ☐ No ☐ Yes

I have explained benefits/risks of home IV therapy
Physician Signature ______________________________ Date______________
Referring Physician (please print) ______________________ Date______________
Most Responsible Physician while on service ______________________________