Hospital Infusion Therapy Referral Form

Enter "LHIN to Assess" and follow instructions on posters on each hospital unit

Name:			
Address:			**Postal Code:**
Sex: ☐ **M** ☐ **F** ☐ **undifferentiated** ☐ **unknown**	**Date of Birth:**		**Phone:**
HCN (mandatory):			**Version Code:**
Primary Diagnosis:			
Other Diagnosis Pertinent to Care:			
Height:	Weight:	Blood Pressure:	Diabetic: ☐ Yes ☐ No
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):

Allergies:

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, Home and Community Care Support Services Central East 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:

Central East Hospital Fax Lines

- ☐ Campbellford Memorial Hospital Fax: 1-844-631-5800
- ☐ Haliburton Highlands Health Services Fax: 1-844-709-3779
- ☐ Northumberland Hills Hospital Fax: 1-844-631-5801
- ☐ Lakeridge Health Ajax Pickering Fax: 905-444-2524
- ☐ Lakeridge Health Bowmanville Fax: 1-844-631-5802
- ☐ Lakeridge Health Oshawa Fax: 905-444-2516
- ☐ Lakeridge Health Port Perry Fax: 1-844-631-5803
- ☐ Lakeridge Health Whitby Fax: 905-444-2518
- ☐ Ontario Shores Fax: 1-844-631-5803
- ☐ Markham Stouffville Uxbridge Site Fax: 1-844-631-5803
- ☐ Peterborough Regional Health Centre Fax: 1-855-444-9628
- ☐ Scarborough and Rouge Hospital – Birchmount Site Fax: 1-844-631-5804
- ☐ Scarborough and Rouge Hospital – General Campus Fax: 1-844-631-5805
- ☐ Scarborough and Rouge Hospital – Centenary Site Fax: 1-844-631-5808
- ☐ Ross Memorial Hospital Fax: 1-844-631-5806

Ontario