[redacted]

COMMUNITY CARE ACCESS CENTRE

(905) 684-9441 OR 1-800-263-5480 FAX (905) 684-8463

Client Name:	Telephone: DOB:
Address:	
Health Card #:	Version: Expiry Date:
Diagnosis:	
Drug Allergies	
Other Medications	
Dilution Solution	Pharmacy will choose unless otherwise specified _____ Glucose restricted ☐ Yes ☐ No
Local Pharmacy	

Flush Instructions:
☐ CCAC IV Treatment Protocol (see details on back)
☐ Other _____

Lock Instructions:
☐ CCAC IV Treatment Protocol (see details on back)
☐ Other _____

Suitability for Pump: Cognitive Ability _____ Status of Veins _____

Infusion Care:
1. If no sign of infection after 72 hrs, may leave peripheral line in. ☐ Yes ☐ No
2. Physician arranged serum levels ☐ Yes Type and frequency _____
   ☐ Not Required
3. If nurse unable to restart IV or administer treatment for any reason, client should: (prescription given to client)
   ☐ call physician ☐ go to ER ☐ miss doses or take _____ p.o. or I.M.

DATE AND TIME FIRST DOSE GIVEN

RX Regular Drug 1

Drug:	_____mg OD BID TID QID (circle one) (for client convenience, order Q8h medications as TID and Q6h as QID)
Duration:	X _____ ☐ weeks ☐ days **Last Dose Date:** Time:
Route:	☐ Peripheral ☐ Hickman ☐ Portcath ☐ SC ☐ _____
Other Instructions:	
	Infuse total dose over _____ minutes.

RX Regular Drug 2

Drug:	_____mg OD BID TID QID (circle one) (for client convenience, order Q8h medications as TID and Q6h as QID)
Duration:	X _____ ☐ weeks ☐ days **Last Dose Date:** Time:
Route:	☐ Peripheral ☐ Hickman ☐ Portcath ☐ SC ☐ _____
Other Instructions:	
	Infuse total dose over _____ minutes.

IV Hydration Orders:
Solution: _____
Amount: _____ per day for _____ days
Rate: _____ ml per hour Lock: ☐ Yes ☐ No
See back of form for recommendations.

Verbal Order Taken By: _____ Date: _____

Physician Name: _____
Address: _____ Tele: _____
(please print) _____ Fax: _____

Physician Signature: _____ Date: _____