niagarahealth
Extraordinary Caring. Every Person. Every Time.

Bayshore HealthCare
Integrated Care Solutions
Harmonizing Patient Care

MRN # _____

Complete or place patient label here

Patient Name: (Print first, last) _____

DOB: ___/___/___ Age: _____ ☐ Female ☐ Male

OHIP #: _____ Version Code: _____

Physician: _____ Date of Admission: ___/___/___

Niagara Health @Home – Medical Treatment Order

Send to ☐ **Bayshore: ICSreferrals@bayshore.ca**

Wound Diagnosis

☐ Pressure Injury – Stage _____ ☐ Venous Ulcer – ABPI _____

☐ Arterial Ulcer ☐ Surgical Wound ☐ Trauma (e.g., burn, skin tear) ☐ Abscess ☐ Malignant Wound

☐ Diabetic Foot ☐ Drain Care ☐ Ostomy ☐ Pilonidal Sinus ☐ VAC/Pico ☐ Skin tear

☐ Other – Specify: _____ ☐ Remove staples, Date: _____

Type of dressing: _____

Wound Location: _____

Wound care consult attached ☐ Yes ☐ No Doctor order required ☐ Yes ☐ No

Additional wound notes/orders: ☐ Yes ☐ No

Medication Orders

☐ IV Medication ☐ IM/SC injections ☐ IV Hydration/Hypodermoclysis

Name of drug: _____ Dose: _____ Route: _____

Frequency: _____ Duration: _____

Last dose given: ___/___/___ Time: _____ Next dose given: ___/___/___ Time: _____

Is first dose required in community? ☐ Yes ☐ No

☐ Peripheral Line ☐ Midline ☐ PICC Non-Valved ☐ PICC Valved ☐ Implanted Port ☐ Tunneled Catheters Tip

Confirmed ☐ Yes ☐ No Last dressing change, date: _____

IV Nurse/IR notes attached ☐ Yes ☐ No Additional Medication Orders: _____

☐ RNAO Flushing and CVAD care protocol

Plan of care for central line post discharge: _____

Foley Catheter

☐ Re-insert ☐ Flushing ☐ Other: _____ Date inserted: ___/___/___ Size: _____

Change Orders: _____ In and out catheterization: _____

Other Orders

Enteral feeding tube ☐ Yes ☐ No Flushing orders attached ☐ Yes ☐ No Dietitian orders attached: ☐ Yes ☐ No

Weight bearing orders attached ☐ Yes ☐ No Other orders attached: ☐ Yes ☐ No

Home O2

ABGs: Date: _____ Pa02____ pH_____ PaC02_____ HC03_____ on ◯ Room Air or on ◯ O_2 at _____L/min

Home Oxygen Prescription: _____L/min at Rest: _____L/min on Exertion (nasal cannula).

Hours of Use/Day: _____

◯ Palliative therapy (no ABGs required) ◯ Patient requires O_2 for transition home

Primary Care Provider Information

PCP Name: _____ Site: _____

Signature: _____ Date: ___/___/___

Phone Number: _____ Fax Number: _____ OHIP Billing #: _____

Additional Information:

_____

_____

_____ Signature and Designation: _____ Date: _____

☐ Not Applicable