Health

MRN # _____ Complete or place patient label here

Patient Name: (Print first, last) _____ Female Male

DOB: _____ Age: _____

OHIP #: _____ Version Code: _____

Physician: _____ Date of Admission: _____

# Niagara Health @home – Medical Treatment Order

**Send to** ☐**SE Health: Niagaraathome@sehc.com** **Submit Form**

## 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: _____ End Date: _____

Last dose given: ____ ____ ____ Time: Is _____ Next dose given: ____ ____ ____ Time: _____

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: _____ ◉Patient requires $O_2$ for transition home

Palliative therapy (no ABGs required) ◉Oxygen delivery method _____

## Provider Information

Name: _____ Site: _____

Signature: _____ Date: ____ ____ ____

Phone Number: _____ Fax Number: _____ OHIP Billing #: _____ (Referring Physician)

**Additional Information:**

_____

_____

Form completed by (print name): _____ Signature and Designation: _____ Date: _____