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| **OUTPATIENT MEDICAL ORDERS** | **\*Required Fields** |
| [ ]  **Direct to Clinic Referral** [ ]  Health Link Referral:       |
|  |  |
| **Relevant Diagnosis** |       |
| **Wound Care** | [ ]  **Wound care as per best practice**  | [ ]  Other – Specify:       |
| Type:       |
| Location:   |
| \*Is the patient a diabetic? [ ]  Yes [ ]  No |
| **\*Medication Orders** | \*[ ]  IV Medication [ ]  IM/SC Injections [ ]  IV Hydration/Hypodermoclysis |
| \***Drug Name:**        | **Dose:**        | **Route:**        |
| **Frequency:**        | **Duration:**        |
| **Dose Given:**        | **Next Dose:**        |
| *(Date/Time dose given in hospital)* | *(Date/Time for next dose to be given)* |
| [ ]  **NEXT DOSE as soon as CCAC can arrange services (within 4 hours of next dose)** |
|       |
| **Catheter Care** | [ ]  Re-insert [ ]  Flush |
|  Indwelling Foley Catheter Care ---Foley Catheter Size\_\_\_\_--Reinsert if blocked or falls out\_ Teach patient/caregiver how to monitor Intake & Output Daily\_\_Teach patient foley catheter care/bag emptying/hygiene\_\_ If catheter becomes blocked, irrigate gently with Sterile Normal Saline 30-60cc In & Out Catheterization Care\_\_ In & Out catheterization twice daily---Start Date\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_ Teach patient/caregiver how to catheterize/self catheterization |
| **Other *\*\*Downtime Use ONLY*** | [ ]  Physiotherapy [ ]  Occupational Therapy [ ]  Personal Support |
| [ ]  Other Specify:       |
| **\*Physician Information** | **PRINT NAME**:       | Hospital:       |
| \*Signature:  | Date (dd-mmm-yyyy):       |
| \*Phone Number:       | \*Fax Number:       |
| \*OHIP Billing#:       |
| **Please note: This form needs to be faxed after sending the referral in Resource Matching and e-Referral (RM&R)** |
| **Signed Physician Medical Orders are not required for Physiotherapy, Occupational Therapy and Personal Support** |