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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)** | | | | | |
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| **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** | | | | | | |