Hospital Medical Treatment Order

*Required Fields

☐ **Direct to Clinic Referral**

Relevant Diagnosis	
Wound Care	* ☐ **Wound Care as per Best Practice Protocol or Select Wound Management Type:** *Location: _____ ☐ Pressure Ulcer – Stage: _____ ☐ Venous Ulcer – Ankle Brachial Pressure Index (ABPI): _____ ☐ Arterial Ulcer ☐ Open Surgical Wound ☐ Trauma (e.g. burn, skin tear) ☐ Abscess ☐ Malignant Wound ☐ Diabetic Foot ☐ Drain Care (Jackson-Pratt (JP) and Percutaneous drains) ☐ Pilonidal Sinus ☐ Ostomy ☐ Other (Specify): ☐ VAC/Pico ☐ Skin Tear
***Medication Orders**	* ☐ Intravenous Medication ☐ Inter-Muscular Injections ☐ Intravenous 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) ☐ Peripheral Line ☐ Midline ☐ PICC Non-Valved ☐ PICC Valved ☐ Implanted Port ☐ Tunneled Catheters *Tip Confirmed: ☐ Yes ☐ No ☐ De-Access Chemotherapy Drug to be De-Accessed: _____ Date: _____ Additional Medication Orders:
Other ***Downtime* Use ONLY**	☐ Occupational Therapy ☐ Personal Support ☐ Physiotherapy ☐ Other (Specify):
***Physician/ Nurse Practitioner Information**	**PRINT NAME:** _____ ***Signature:** _____ **Date:** _____ (dd-mmm-yyyy) ***CPSO #:** _____ **Hospital:** _____ ***Phone Number:** **Fax Number:**

Please Note: This form needs to be faxed after sending the referral in Resource Matching and e-Referral (RM&R)

If patient not seen by Care Coordinator, send home 2 days of dressing supplies