

***Required Fields**

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Relevant Diagnosis	
Wound Care	☐ Wound Care as per Best Practice ☐ Other - Specify: _____ Type: _____ Location: _____ *Is the Patient a Diabetic? ☐ Yes ☐ No
*Medication Orders	* ☐ Intravenous Medication ☐ Inter-Muscular/Subcutaneous 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 Catheter *Tip Confirmed: ☐ Yes ☐ No ☐ De-Access Chemotherapy Drug to be De-Accessed: _____ Date: _____ Additional Medication Orders:
Urinary Catheter Care	☐ Re-Insert ☐ Foley Catheter Care ☐ Irrigate with 30 mL Normal Saline PRN ☐ Re-Insert/Change (If Required) ☐ Discontinued Foley on: _____ (dd-mmm-yyyy) Comments:
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: _____

Signed Physician/NP Medical Orders are not required for Occupational Therapy, Personal Support and Physiotherapy