First Dose Intravenous Therapy in the Community Risk Assessment Form

Contact HCCSS HNHB at 1-800-810-0000 Fax completed copy to 1-866-655-6402

Patient Name _____ **HCN** _____ **VC** _____ **DOB** _____

Address _____ **City** _____ **Province** _____ **Postal Code** _____

Patient Phone _____ **Contact Name** _____ **Contact Phone** _____

PART 1: Patient is eligible for first dose IV in the community without further assessment if they meet one of the following reasons below (IF ELIGIBLE - NO NEED TO COMPLETE PART 2).

Select reason for eligibility and complete medical orders:

- ☑ Medication is pre-approved for first dose (dexamethasone, dimenhydrinate, diphenhydramine, magnesium, octreotide, potassium chloride, potassium phosphate, pantoprazole, ranitidine, vancomycin, ferric derisomaltose (FD), remdesivir)
- ☐ Patient resides in a Long-Term Care Home
- ☐ Patient has no prior history of allergy to medication in the same class that is being prescribed

****If patient does not meet any reason listed above for eligibility, proceed to Part 2****

PART 2: Only complete if patient NOT eligible in Part 1

First Dose Risk Assessment – Must answer YES to all questions to be eligible to receive the first dose in the community setting:

	Yes	No
1. Patient does not have any serious allergies, adverse reactions or anaphylactic reactions to the ordered medication, related drugs or unknown origin.	☐	☐
2. The signs and symptoms of anaphylactic reaction have been explained to the patient or caregiver.	☐	☐
3. The medication is not: Amikacin, Amphotericin Deoxycholate, Antineoplastic, Colistin, Gentamycin, Gold Therapy, Investigational, Iron Sucrose, or Tobramycin.	☐	☐
4. The patient is not on a beta blocker.	☐	☐
5. The patient is at least 1 year old and weighs at least 10 kg.	☐	☐
6. The patient has a working telephone.	☐	☐
7. There is a capable adult (18 years or older) available to remain in the home for 6 hours post completion of medication administration.	☐	☐
8. Hospital emergency department is within 30 minutes of where first dose would be administered.	☐	☐

☐ I have explained the risks of having the first dose in the community to the patient/ substitute decision maker and the patient/substitute decision maker has given verbal consent.

Practitioner (MD/NP) Completing the Risk Assessment Form:

Name _____ **CPSO/CNO Reg.#** _____

Phone _____ **Backline or Cell** _____ **Fax** _____

Signature: _____ **Date:** _____

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Ontario