

**Medical Day Care Unit
(MDCU)
General Order Form**

Addressograph

Contact and Referral Instructions

Phone: 613-732-2811 x 6650 Fax: 613-633-4594

**** Please ensure that all applicable forms are sent at the time of order****

General Orders:

Please attach a summary of patient history, medications, allergies and relevant diagnoses from your EMR

Provider Print Name:	Provider Signature:	Date (DD/MMM/YYYY):

Provider Phone:	Fax:	Email:	CPSO/CNO/CMO#:

Epic EMR Requirements (effective October 13, 2026)

For providers able to submit therapy plans through Epic to the PRH MDCU:

Please complete and submit the therapy plan in Epic. Do not send a paper order. The ordering provider remains the Most Responsible Provider (MRP) and must be available throughout treatment.

For providers unable to submit therapy plans through Epic to the PRH MDCU:

Please submit the paper order along with all required documentation. A PRH provider will assume the MRP role during treatment.

MDCU General Order Form Additional Information

Important Patient Criteria

The Pembroke Regional Hospital Medical Day Care Unit treats stable, non-urgent adult patients aged 18 years and older. Patients must be able to self-transfer, use the toilet and remain seated for the duration of their treatment, either independently or with help from a designated support person. Patients are booked by priority and wait times of 5-10 business days may occur.

Designated Using Blood Wisely Hospital

As a Designated Using Blood Wisely Hospital, PRH encourages thoughtful and evidence-informed transfusion practices. Ordering providers are encouraged to consider restrictive transfusion thresholds where clinically appropriate, while considering individual patient factors and clinical judgment.

Required Documentation for Epic and Paper Orders

- ☐ Please attach a summary of patient history, medications, allergies and associated diagnoses
- ☐ IVIG orders require a completed **“MOHLTC IVIG/IGSP Form”**
- ☐ Informed consent for treatment, including risks and benefits, must be completed by the ordering provider to avoid delays on the day of treatment.
- ☐ Blood and blood products require a digitally signed consent in Epic, or, if using paper orders, a **“Patient Consent for Blood Transfusion or Blood Products”** signed by ordering Physician (or delegate) and Patient or substitute decision maker. Consents are good for 12 months and are held at MDCU for 12 months.

Additional Required Documentation for Paper Orders

- ☐ Standing orders for red blood cells and platelets must include treatment parameters, including hemoglobin thresholds and frequency, such as every 1 week for 6 months.
- ☐ IV Iron orders require a completed **“Outpatient Intravenous Iron PPO”**
- ☐ PICC orders require a completed **“Peripherally Inserted Central Catheter PPO”**
- ☐ Community Paracentesis orders require a completed **“Ultrasound Guided Abdominal Paracentesis PPO”** and **“Patient Consent for Blood Transfusion or Blood Products”**, if albumin is ordered. Paracentesis orders must also be sent to Diagnostic Imaging Fax at 613-732-6349. Standing Orders are valid for 3 months.

Patient Consent for Blood Transfusion or Blood Products

TO BE COMPLETED BY THE PATIENT OR SUBSTITUTE DECISION MAKER

Your physician (or delegate) has indicated that you need or may need a blood transfusion.

Your physician (or delegate) has explained:

- The reason for the transfusion.
- The type of blood product(s) needed.
- The expected benefits.
- The risk and side effects.

Your physician (or delegate) has also informed you of:

- Any available alternatives to transfusion.
- The possible risks of refusing transfusion.

Your physician (or delegate) has addressed your questions about transfusion.

I understand the information provided to me, and the physician (or delegate) has addressed my questions including any requests for additional information. I agree to receive blood or blood products.

Name of Patient / Substitute Decision Maker

Signature

Date (day-month-year)

Name of Physician (or delegate)

Signature

Date (day-month-year)

Name of Interpreter if Required

Signature

Date (day-month-year)

TELEPHONE CONSENT SIGNATURES:

Substitute Decision Maker

Physician (or delegate)

Witness

Date (day-month-year)

TO BE COMPLETED BY THE PHYSICIAN (OR DELEGATE)

Duration of consent to be valid for:

- ☐ The current admission or visit.
- ☐ (For Medical Day Care / Systemic Therapy only). Period up to 12-months as per treatment plan.

Name of Physician (or delegate)

Signature

Date (yyyy-mm-dd)

For non-neurology use only

Patient Name
Patient Hospital/Medical Record#
D.O.B.
Gender
Location
Ontario Health Insurance#

ALL FIELDS BELOW ARE MANDATORY

Date Requested: (YYYY/MM/DD)	Treating Physician:
Date Required: (YYYY/MM/DD)	Physician Specialty:
Hospital where patient will receive IG.	Physician Phone #:

Dosage Information: (Verification of dose using [Dose Calculator](#) tool is recommended)

☐ Intravenous IG (IVIG)		☐ Subcutaneous IG (SCIG)	
Patient Weight: kg	Patient Height: cm	BMI:	Dose must be adjusted for BMI greater than or equal to 30
☐ Induction/One-time dose	g/kg = Total dose of	g; divided over	days
☐ Maintenance dose	g/kg = Total dose of	g; divided over	days; every weeks; Duration: months
Dose Calculator Used? ☐ Yes ☐ No If No, why was it not used			
IgG level/Platelet count/other test results relevant to patient condition: Result: Date:			

Clinical indication for use: Refer to [Ontario IG Management Utilization Guidelines](#) for additional indications where IG may be appropriate.

Specialty	
Hematology	☐ Fetal/Neonatal Alloimmune Thrombocytopenia (F/NAIT)
	☐ Hemolytic Disease of the Fetus and Newborn (HDFN)
	☐ Immune Thrombocytopenia (ITP) ☐ Adult ☐ Pediatric
	☐ Post-transfusion Purpura
Dermatology	☐ Pemphigus Vulgaris (PV) and Variants
Rheumatology: Pediatric	☐ Juvenile Idiopathic Inflammatory Myopathy (J-IIM) (previously Juvenile Dermatomyositis)
	☐ Kawasaki Disease (KD)
Rheumatology: Adult	☐ Idiopathic Inflammatory Myopathy (IIM) Includes Dermatomyositis and Polymyositis
Immunology	☐ Primary Immune Deficiency (PID)
	☐ Secondary Immune Deficiency (SID)
	☐ Hematopoietic Stem Cell Transplant in primary immunodeficiencies
Solid Organ Transplant	☐ Kidney transplant from living donor to whom the patient is sensitized
	☐ Pre-transplant (Heart)
	☐ Peri-transplant (heart, lung, kidney, pancreas)
	☐ Post-transplant
Infectious Disease	☐ Invasive Group A streptococcal fasciitis with associated toxic shock
	☐ Staphylococcal Toxic Shock
*OTHER (requires approval)	

For Transfusion Medicine Use Only

☐ Dose verified ☐ Dose adjusted to:	By (signature req'd):
☐ Confirmed with ordering physician	Date:
☐ Approved ☐ Denied	Date:
Signature of Approving Physician:	

Medical Condition	Suggested initial dose and duration
Fetal/Neonatal Alloimmune Thrombocytopenia (F/NAIT)	<i>Maternal:</i> Previous fetus with intracranial hemorrhage: Up to 2 g/kg/week starting as early as 12-16 weeks gestation. No previous fetus with intracranial hemorrhage: Up to 1 g/kg/week. Starting as early as 20 -26 weeks current gestation. <i>Infant:</i> Initial dose of 1 g/kg reassess following initial dose.
Hemolytic Disease of the Fetus and Newborn (HDFN)	0.5 g/kg over 4 hours
Immune Thrombocytopenia (ITP) Adult	<i>Acute:</i> 1 g/kg as a single dose. Repeat if PLT count does not respond i.e. still less than 30×10^9 /L. <i>Chronic:</i> In consultation with a hematologist, as adjunctive therapy or where other therapies have failed or are not appropriate. Consider 1-2 g/kg. The use of regular IVIG as a treatment for chronic ITP should be considered as exceptional and alternative approaches (e .g. splenectomy, rituximab, thrombopoietin receptor agonists) should be considered.
Immune Thrombocytopenia (ITP) Pediatric	For patients who require treatment, a single dose of IVIG may be considered a front-line treatment (0 .8 to 1 g/kg). A second dose can be repeated if there is no clinical response. IVIG will result in a faster increment in platelet count compared with steroids. In emergent management, IVIG is recommended as part of multimodal therapy
Post-transfusion Purpura	Up to 2 g/kg divided over 2 to 5 consecutive days. Repeat if necessary; for short term use.
Pemphigus Vulgaris (PV) and variants	Total dose of 2 g/kg divided over 2 to 5 days every 4 weeks. Dose every 6 weeks after 6 months of therapy.
Juvenile Idiopathic Inflammatory Myopathy (J-IIM) (previously Juvenile Dermatomyositis)	<i>Initial dose:</i> Total dose of 2 g/kg divided over 2 days. <i>Maintenance dose:</i> A systematic approach should be taken to determine minimum effective dose.Continued use should be based on objective measures of sustained effectiveness. Maximum dose should not exceed 2 g/kg.
Kawasaki Disease (KD)	2 g/kg for 1 day (second dose can be given for patients that fail to respond to initial dose).
Idiopathic Inflammatory Myopathy (IIM) Includes Dermatomyositis and Polymyositis * does not include Inclusion Body Myositis	Maximum dose is 2 g/kg to be given over 2 days initially monthly for 3-6 months and if effective to be continued at decreasing frequency (determine minimum effective dose) over approximately 2 years.Survival of patients with IIM has been shown to be substantially improved in patients given IVIG.
Primary Immune Deficiency (PID) Secondary Immune Deficiency(SID)	<i>Adult:</i> 0.4-0.6 g/kg every 3-4 weeks <i>Pediatric:</i> 0.3-0.6 g/kg every 3-4 weeks Doses or frequency to be adjusted by experts according to desired trough level (more than 500 mg/dL and ideally 700 mg/dL) and according to individual patient clinical needs.
Hematopoietic Stem Cell Transplant in primary immunodeficiency	0.4-0.6 g/kg every 3-4 weeks; requirements may increase and should be based on clinical outcome.
Kidney transplant from living donor to whom the patient is sensitized	2 g/kg/month for 4 months.
Pre-transplant (Heart)	Suggested dose up to 1 g/kg/month until transplant.
Peri-transplant (heart, lung, kidney, pancreas)	Suggested dose 1 g/kg can give as divided doses if in association with a course of plasmapheresis.
Post-transplant	<i>Acute:</i> 1 g/kg/dose. Can be given as divided doses if in association with a course of plasmapheresis. <i>Chronic:</i> 1 g/kg/month.
Invasive Group A streptococcal fasciitis with associated toxic shock	1 g/kg on day one and 0 .5 g/kg per day on days 2 and 3 OR 0.15 g/kg per day for 5 days .
Staphylococcal Toxic Shock	

* Refer to [Ontario IG Management Utilization Guidelines](#) for additional indications where IG may be appropriate.

If you are unsure of the process for IG requests please refer to [Ordering IG in Ontario](#)

PHYSICIAN'S ORDERS ADULT OUTPATIENT INTRAVENOUS IRON

Medication Allergies/Reactions:

☐ None Known

Substances or Food Allergies/Reactions:

☐ None Known

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Age: _____

Weight: _____(kg)

Room #: _____

Init.	Non-Medication	Init.	IV and Medication (Medication, dose, route, frequency)
	CRITERIA FOR OUTPATIENT ADMINISTRATION OF INTRAVENOUS IRON: ☐ Diagnosis of iron deficiency anemia: Hemoglobin (Hgb) levels less than 120 g/L in females or less than 130 g/L in males AND ☐ Low iron stores demonstrated by transferrin saturation (TSAT) less than 20% (0.20) AND/OR ferritin less than 30 mcg/L AND ☐ Insufficient time (4 weeks or less) to evaluate efficacy of oral therapy for upcoming procedure (e.g. prior to surgery) OR documented severe intolerance/inadequate response to appropriate trial of oral therapy OR inability to absorb oral iron OR ☐ If ordering outside of criteria (restless legs, bariatric surgery, chronic inflammation, etc.) please specify below: ELIGIBILITY FOR INSURED SERVICES: ☐ Third-party Drug Coverage or Self-Pay ☐ Prescriber to provide patient with prescription for Iron Sucrose or Ferric derisomaltose (Monoferric) for community pharmacy ☐ ODB Coverage ☐ Ferric derisomaltose (Monoferric) prescriber to use LU Code 610 and provide patient with prescription for community pharmacy ☐ Iron sucrose (Venofer) prescriber to complete ODB Exceptional Access Program Request for IV Iron Sucrose and provide patient with prescription for community pharmacy ☒ Informed consent obtained by physician. PATIENT MONITORING: ☒ Vital Signs pre-infusion and q1h during and at least 30 minutes after infusion and PRN ☒ Hold IV Iron if patients temperature is above or equal to 37.8 degrees Celcius		INTRAVENOUS IRON: <u>See IV iron dosing guide.</u> If more than one course of therapy is needed (based on maximum dose), after completion of a course of therapy, a new order must be submitted. ☐ Ferric derisomaltose (Monoferric) Total dose per course _____ mg (maximum 1 course per order) Give iron ferric derisomaltose _____ mg IV x 1 dose, and (if divided dose required) give _____ mg IV x 1 dose at least 7 days after the first dose (maximum 1500 mg per single dose) OR ☐ Iron sucrose (Venofer) Dose: _____ mg IV every _____ (frequency) X _____ doses (maximum 6 doses per course, preferred maximum dose 300 mg) Additional Orders: PRN: ☒ Acetaminophen 325-650 mg PO/PR x1 PRN for myalgias ☒ Cetirizine 10mg PO x 1 PRN for symptoms of allergic reaction ☒ Famotidine 20mg IV x 1 PRN for symptoms of allergic reaction ☒ diphenhydramine 25-50mg PO/IV x 1 PRN for symptoms of anaphylaxis (itch/hives) ☒ dimenhydrinate 25-50mg PO/IV x 1 PRN for nausea ☒ Methylprednisolone sodium succinate 20mg IV x 1 PRN for infusion reaction OR ☒ Hydrocortisone sodium succinate 100mg IV x 1 PRN for infusion reaction

Date (DD/MMM/YYYY)	Time	Physician (printed)	Signature (Physician)
Date (DD/MMM/YYYY)	Time	Processed by (printed/signature)	Second Verifier (printed/signature)

 PHYSICIAN'S ORDERS Peripherally Inserted Central Catheter (PICC) Insertion			
Medication Allergies/Reactions: ☐ None Known		Substances or Food Allergies/Reactions: ☐ None Known	
Page 1 of 1 Age: _____ Weight: _____(kg) Room #: _____			
Init.	Non-Medication	Init.	IV and Medication (Medication, dose, route, frequency)
	Refer to the Peripheral Inserted Central Catheter (PICC) Insertion: In Clinical Skills Manual ☐ Informed consent obtained by physician Diagnosis: _____ Relevant Medical History: _____ _____ ANTICOAGULATED: ☐ Yes ☐ No PICC INDICATION: ☐ IV antibiotics: _____ ☐ TPN ☐ Hydration ☐ Poor IV access ☐ Other: _____ Isolation/Precautions: _____ _____ MOBILITY STATUS: ☐ Independent ☐ Assisted transfer ☐ Mechanical Lift ☐ Unable to go to Medical Day Care ☐ W/C Chest x-ray post insertion to confirm tip placement Repeat chest X-ray as clinically indicated (for re-guides) Notify Physician if unable to place the PICC successfully Refer to the Peripheral Inserted Central Catheter (PICC) Policy available in Clinical Skills Manual Have most responsible physician (MRP) fill in the Peripheral Inserted Central Catheter (PICC) Pre-Printed Order for the care and maintenance		Lidocaine 1% 0.5 mL to 2 mL intradermal

INCOMPLETE ORDERS WILL NOT BE PROCESSED

Date (YYYY/MMM/DD)	Time	Physician (printed)	Signature (Physician)
Date (YYYY/MMM/DD)	Time	Processed by (printed/signature)	Second Verifier (printed/signature)

☐ COPY SENT TO PHARMACY

May 2025

PHYSICIAN'S ORDERS

Paracentesis - Ultrasound Guided Abdominal Procedure

Medication Allergies/Reactions:

Substances or Food Allergies/Reactions:

☐ None Known

☐ None Known

Page 1 of 1

Age: _____

Weight: _____(kg)

Room #: _____

Init.

Non-Medication

Init.

IV and Medication (Medication, dose, route, frequency)

- ☐ Inpatient/Emergency Department (one-time)
☐ Outpatient (order valid for 3 months from date signed)

- ☐ I certify that I have ordering privileges at PRH.
☐ I am available at _____ (phone) on the day of the procedure for clarification of the physician orders and/or to discuss complications. (A physician needs to be available during the monitoring phase for consultation.)

DRAINAGE:

- ☐ Drain fluid until drainage slows to a max of 10 litres.

OR

- ☐ Drain to specific target of _____ litres of fluid.

THEN

- ☒ Remove drain upon completion, as per PRH clinical skill.

OR

- ☐ Leave drain in place until: _____.

ADDITIONAL NON-MEDICATION ORDERS:

ALBUMIN:

- ☒ Usual Albumin Replacement:

- If less than 6L fluid removed, give 1 unit (100mL) of 25% albumin.
- If 6-7.9L fluid removed, give 2 units (200mL) of 25% albumin.
- If 8-10L fluid removed, give 3 units (300mL) of 25% albumin.

OR

- ☐ Give albumin per physician specifications:

ADDITIONAL MEDICATION ORDERS:

NOTE: Outpatient Orders are only valid until 3 months from date of signature.

Date (YYYY/MM/DD)	Time	Physician (printed)	Signature (Physician)
Date (YYYY/MM/DD)	Time	Processed by (printed/signature)	Second Verifier (printed/signature)

Diagnostic Imaging (DI) Requisition

Patient email: _____

PRH Telephone Number: (613) 732-4141, PRH DI MAIN Fax Number: (613) 732-6349

Computed Tomography (C.T.) & Nuclear Medicine Fax Number: (613) 633-4579

Preferred Language: ☐ English ☐ French

Examination(s) Requested:				Precautions: ☐ Contact ☐ Droplet ☐ Airborne ☐ Mask/Shield Location of Patient:											
Patient History and Pertinent Lab Results:				Mode of Transportation (In-Patients): ☐ wheelchair ☐ stretcher ☐ bed ☐ ambulatory ☐ portable ☐ fall risk			Oxygen required: Yes No ☐ ☐								
Y N		Please check the following if applicable		Y N		Contrast Nephropathy Risk Factors		Y N		Possible MRI Contraindications					
		☐ ☐ Renal impairment ☐ ☐ Family history of End Stage Renal Disease ☐ ☐ Dialysis Treatment ☐ ☐ Metformin Treatment ☐ ☐ Pregnant ☐ ☐ Beta-hCG level:				☐ ☐ Diabetes Mellitus ☐ ☐ Cardiac Disease ☐ ☐ Hypertension ☐ ☐ Nephrotoxic drugs: ☐ ☐ Immunosuppression: ☐ ☐ Collagen vascular disease ☐ ☐ Dehydration, sepsis, shock				☐ ☐ Aneurysm surgery ☐ ☐ Intraocular lens implant/Prior metal fragment ☐ ☐ Eye surgery (excluding lens implants, cataract or laser) ☐ ☐ Ear surgery (excluding ear tubes) ☐ ☐ Cardiac Pacemaker ☐ ☐ Implanted stimulators, electrodes, electronic devices ☐ ☐ Any filters, stents, coils, grafts or shunts					
Bone Density (BMD) ☐ Baseline (first BMD in Ontario) ☐ 2 nd Low Risk (at 36 Months) ☐ 3 rd Low Risk (at 60 Months) ☐ High Risk (once every 12 Months)		Creatinine Clearance or eGFR required for patients with ≥1 contrast nephropathy risk factors. Please provide the most recent value, date (within 3 months), and location of the test. Report required if test was not preformed at PRH.		MRI is contraindicated for all patients with pacemakers or defibrillators. Please forward operative report and specify the (stickers of make and model).											
Breast Imaging: Implants: ☐ Yes ☐ No Last mammogram: Date: Location:		Location: <table style="width: 100%; border: none;"> <tr> <td style="border: none; width: 33%;">Cr level:</td> <td style="border: none; width: 33%;">eGFR level:</td> <td style="border: none; width: 33%;">Date of test:</td> </tr> <tr> <td style="border: none; height: 30px;"></td> <td style="border: none; height: 30px;"></td> <td style="border: none; height: 30px;"></td> </tr> </table>		Cr level:	eGFR level:	Date of test:				Device:		Date:		Institution of Surgery:	
Cr level:	eGFR level:	Date of test:													
Ordering Practitioner (Print): Signature: Billing Number:															
Office Telephone Number: Fax Number: Pager Number:															
Copy of report to: Address: Fax Number:															
OFFICE USE ONLY															
Protocol:															
Priority Code		Protocolled by		eGFR Required? ☐ Yes ☐ No ☐ 1m ☐ 3m				Appointment Date: Time:							