Oregon Health & Science University Hospital and Clinics Provider's Orders PO7071 ADULT AMBULATORY INFUSION ORDER **Therapeutic Phlebotomy** Page 1 of 2	ACCOUNT NO. MED. REC. NO. NAME BIRTHDATE *Patient Identification*

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING:

1. Send **FACE SHEET and H&P or most recent chart note**.
2. Labs (H&H or CBC) must be drawn within 30 days prior to phlebotomy.
3. Ferritin must be drawn within 90 days prior to phlebotomy.
    a. If phlebotomy parameters are based on Ferritin level, H/H results and parameters must be ordered at each visit to rule out anemia.

LABS:

- ☐ Hemoglobin & Hematocrit, Routine, ONCE, every visit
- ☐ Ferritin (serum), routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ Labs already drawn. Date: _____

NURSING ORDERS:

1. VITAL SIGNS – Pre-phlebotomy and orthostatic vital signs prior to discharge.
2. TREATMENT PARAMETERS:
    a. Perform phlebotomy if:
        i. Hgb is greater than or equal to: _____ mg/dL
        OR
        ii. Hct is greater than or equal to: _____ %
    b. Ferritin goal is: _____
3. TREATMENT PARAMETERS – Notify provider if vital signs abnormal.
4. Discharge 30 minutes after phlebotomy complete and after orthostatic vital signs are completed.
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

THERAPEUTIC PHLEBOTOMY:

Phlebotomize _____ mL of blood as directed (no more than 500 mL at one time).

Interval: (must check one)

- ☐ Once
- ☐ Weekly
- ☐ Every other week
- ☐ Once monthly

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AS NEEDED MEDICATIONS:

1. Sodium chloride 0.9% bolus, 1000 mL, intravenous, AS NEEDED x 1 dose, if after phlebotomy standing SBP drops by greater than or equal to 20 points from reclined SBP OR standing DBP drops by greater than or equal to 10 points from reclined DBP and symptomatic (pallor, diaphoresis, nausea, dizziness, fainting). Contact provider if additional orders needed.

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

Central Intake:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient's preferred clinic location:

☐ **Beaverton**
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

☐ **NW Portland**
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

☐ **Gresham**
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

☐ **Tualatin**
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders