Oregon Health & Science University Hospital and Clinics Provider's Orders PO7071 ADULT AMBULATORY INFUSION ORDER **Other Therapy** Page 1 of 3	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. Medications may require a 24 hour turn-around time before they are available at specific clinic locations. Please consider contacting the clinic pharmacist to determine availability prior to scheduling patient.

MEDICATIONS:

Analgesics:

- ☐ acetaminophen (TYLENOL) tablet, _____ mg, oral, ONCE
- ☐ HYDROmorphone (DILAUDID) injection, _____ mg, intravenous, ONCE
- ☐ ibuprofen (ADVIL) tablet, _____ mg, oral, ONCE
- ☐ ketorolac (TORADOL) injection, _____ mg, intravenous, ONCE
- ☐ morphine injection, _____ mg, intravenous, ONCE

Interval: *(must check one)*

- ☐ ONCE
- ☐ Daily x _____ doses
- ☐ Every _____ days x _____ doses

Diuretics:

- ☐ chlorothiazide (DIURIL) injection, _____ mg, intravenous, ONCE
- ☐ furosemide (LASIX) injection, _____ mg, intravenous, ONCE (doses over 80 mg will be dispensed in a bag)

Interval: *(must check one)*

- ☐ ONCE
- ☐ Daily x _____ doses
- ☐ Every _____ days x _____ doses

Octreotides:

- ☐ octreotide, microspheres (SANDOSTATIN LAR) 20 mg, intramuscular, ONCE
- ☐ octreotide, microspheres (SANDOSTATIN LAR) 30 mg, intramuscular, ONCE

Interval: *(must check one)*

- ☐ ONCE
- ☐ Daily x _____ doses

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☐ **Calcitriol (CALCIJEX)** injection, _____ mcg, intravenous, ONCE
Interval: *(must check one)*
- ☐ ONCE
- ☐ Daily x _____ doses

☐ **Cyanocobalamin (VITAMIN B-12)** injection, 1000 mcg, subcutaneous, ONCE
Interval: *(must check one)*
- ☐ ONCE
- ☐ Daily x _____ doses

☐ **Desmopressin (DDAVP)** _____ mcg in NaCl 0.9% 50 mL, intravenous, ONCE
Interval: *(must check one)*
- ☐ ONCE
- ☐ Daily x _____ doses

☐ **Dihydroergotamine (DHE)** injection, 1 mg, intravenous, ONCE
Interval: *(must check one)*
- ☐ ONCE
- ☐ Daily x _____ doses
- ☐ Every _____ hours x _____ doses

☐ **Fat emulsion (INTRALIPID)** 20%, _____ mL, intravenous, ONCE (100, 250, or 500 mL)
Interval: *(must check one)*
- ☐ ONCE
- ☐ Daily x _____ doses

☐ **HydrOXYzine (VISTARIL)** injection, _____ mg, intramuscular, ONCE
Interval: *(must check one)*
- ☐ ONCE

☐ **Meperidine (DEMEROL)** injection, _____ mg, intravenous, ONCE
Interval: *(must check one)*
- ☐ ONCE

☐ Other (drug, dose, route): _____
Interval: *(must check one)* *(Pharmacist to confirm availability)*
- ☐ ONCE
- ☐ Daily x _____ doses
- ☐ Every _____ days x _____ doses
- ☐ Every _____ weeks x _____ doses

NURSING ORDERS:

1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

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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