Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071

ADULT AMBULATORY INFUSION ORDER

Dialysis Catheter TPA (Alteplase)

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****

NURSING ORDERS:

1. Aspirate 3 mL of blood from each dialysis lumen to remove high dose heparin prior to flushing
2. Refer to nursing and IV therapy guidelines for care of central venous catheters
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

MEDICATIONS:

INFUSION ORDERS

LUMEN #1

☐ alteplase (ACTIVASE) 4 mg in sodium chloride 0.9% 100 mL, intracatheter, ONCE over 2 hours as needed for occluded dialysis catheter lumen (Maximum of 8 mg total in all lumens)

LUMEN #2

☐ alteplase (ACTIVASE) 4 mg in sodium chloride 0.9% 100 mL, intracatheter, ONCE over 2 hours as needed for occluded dialysis catheter lumen (Maximum of 8 mg total in all lumens)

POST INFUSION ORDERS

LUMEN #1

☐ alteplase (ACTIVASE) 2 mg, intracatheter, ONCE, Label dressing "TPA dwell" with date, time, and RN initials

OR

☐ heparin 1000 units/mL, 1-5 mL, intracatheter, ONCE, Pack dialysis catheter with the volume of catheter plus 0.25 mL

LUMEN #2

☐ alteplase (ACTIVASE) 2 mg, intracatheter, ONCE, Label dressing "TPA dwell" with date, time, and RN initials

OR

☐ heparin 1000 units/mL, 1-5 mL, intracatheter, ONCE, Pack dialysis catheter with the volume of catheter plus 0.25 mL

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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