



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

PO7071



ADULT AMBULATORY INFUSION ORDER  
**Testosterone Cypionate  
(DEPO-TESTOSTERONE)**

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.

**MEDICATIONS:**

**Dose:**

- testosterone cypionate (DEPO-TESTOSTERONE) injection, \_\_\_\_\_ mg, intramuscular, ONCE

**Interval: (must check one)**

- Once
- Every \_\_\_\_\_ weeks x \_\_\_\_\_ doses
- Every \_\_\_\_\_ weeks until discontinued
- Other: \_\_\_\_\_

**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: \_\_\_\_\_



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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](http://www.ohsuknight.com/infusionorders)