



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****

LABS:

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

THERAPEUTIC PHLEBOTOMY:

Amount to be removed: _____ mL, ONCE (no more than 500 mL at one time)

Interval: (must check one)

- Once
- Weekly
- Every other week
- Once monthly

NURSING ORDERS:

1. TREATMENT PARAMETERS:
 - a. Perform phlebotomy if:
 - i. Hgb is greater than: _____ mg/dL
 - ii. Hct is greater than: _____ %
 - b. Other: _____
 - c. Ferritin goal is: _____
2. VITAL SIGNS – Pre-phlebotomy and every 30 minutes
3. TREATMENT PARAMETERS – Notify provider if vital signs abnormal.
4. Discharge 30 minutes after phlebotomy complete or when stable.
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, dec clotting (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:** _____

OLC Central Intake Nurse:

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