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
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

HydroOXYzine (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.
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