**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:**

**Antiemetics:**
- dexamethasone (DECADRON) ______ mg, intravenous, ONCE
- diphenhydramine (BENADRYL) ______ mg, intravenous, ONCE
- lorazepam (ATIVAN) ______ mg, intravenous, ONCE
- metoclopramide (REGLAN) ______ mg, intravenous, ONCE
- ondansetron (ZOFRAN) ______ mg, intravenous, ONCE
- prochlorperazine (COMPAZINE) ______ mg, intravenous, ONCE
- promethazine (PHENERGAN) ______ mg, intravenous, ONCE

**Acid Suppressants:**
- omeprazole (PRILOSEC) capsule, ______ mg, oral, ONCE
- famotidine (PEPCID) 20 mg, intravenous, ONCE
- pantoprazole (PROTONIX) 40 mg in NaCl 0.9% 100 mL, intravenous, ONCE, over 30 minutes

---

Weight: ________ kg  Height: ________ cm

Allergies:

Diagnosis Code:

Treatment Start Date: ______________  Patient to follow up with provider on date: ______________
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