



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

PO7071



ADULT AMBULATORY INFUSION ORDER
Antiemetics & Acid Suppressants

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.**
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 (ZOFTRAN) _____ 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



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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