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:

**Factor:** *(Pharmacist will use most recent weight and round dose to the nearest vial)*
- □ Antihemophilic Factor – VWF (HUMATE-P) _________ units/kg, intravenous, ONCE (dosing based on international units of vWF)
- □ Antihemophilic Factor VIII (recomb) (RECOMBinate) _______ units/kg, intravenous, ONCE

**Interval:** *(must check one)*
- □ Once
- □ Daily x _____ doses
- □ Every _____ days x _____ doses

**Antithrombotics:**
- □ Enoxaparin _____ mg, subcutaneous, ONCE (pharmacist will round dose during order verification)
- □ Fondaparinux _________ mg, subcutaneous, ONCE

**Interval:** *(must check one)*
- □ Once
- □ Daily x _____ doses
- □ Every _____ days x _____ doses

**Albumin:** *(pharmacist will round dose during order verification)*
- □ Albumin 5% _____ grams/kg = _______ grams, intravenous, ONCE
- □ Albumin 25% ____ grams/kg = _______ grams, intravenous, ONCE

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.

<table>
<thead>
<tr>
<th>Provider signature: ____________________________</th>
<th>Date/Time: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed Name: ________________________________</td>
<td>Phone: ____________________________ Fax:________________________</td>
</tr>
</tbody>
</table>

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