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:

Vaccines:
- □ Diphtheria-acellular pertussis-tetanus vaccine (ADACEL booster) 0.5 mL, intramuscular, ONCE
- □ Haemophilus b polysac-tetanus toxoid vaccine (ActHIB) 0.5 mL, intramuscular, ONCE
- □ Hepatitis B vaccine (ENGEXIX-B) 20 mcg/mL, intramuscular, ONCE
- □ Herpes zoster virus vaccine (ZOSTAVAX) 0.65 mL, subcutaneous, ONCE
- □ Influenza vaccine 0.5 mL, intramuscular, ONCE (for 3 years of age and older)
- □ Influenza HD vaccine 0.5 mL, intramuscular, ONCE (for 65 years of age and older)
- □ Meningococcal polysaccharide vaccine (MENOMUNE) 0.5 mL, subcutaneous, ONCE
- □ Pneumococcal (23 valent) polysaccharide vaccine (PNEUMOVAX) 0.5 mL, intramuscular, 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.

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