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**

**NURSING ORDERS:**
1. Aspirate 3 mL of blood from each dialysis lumen to remove high dose heparin prior to flushing
2. Refer to nursing and IV therapy guidelines for care of central venous catheters
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

**MEDICATIONS:**

**INFUSION ORDERS**

**LUMEN #1**
- [ ] alteplase (ACTIVASE) 4 mg in NaCl 0.9% 100 mL, intracatheter, ONCE over 2 hours as needed for occluded dialysis catheter lumen (Maximum of 8 mg total in all lumens)

**LUMEN #2**
- [ ] alteplase (ACTIVASE) 4 mg in NaCl 0.9% 100 mL, intracatheter, ONCE over 2 hours as needed for occluded dialysis catheter lumen (Maximum of 8 mg total in all lumens)

**POST INFUSION ORDERS**

**LUMEN #1**
- [ ] alteplase (ACTIVASE) 2 mg, intracatheter, ONCE, Label dressing "TPA dwell" with date, time, and RN initials

**OR**
- [ ] heparin 1000 units/mL, 1-5 mL, intracatheter, ONCE, Pack dialysis catheter with the volume of catheter plus 0.25 mL

**LUMEN #2**
- [ ] alteplase (ACTIVASE) 2 mg, intracatheter, ONCE, Label dressing "TPA dwell" with date, time, and RN initials

**OR**
- [ ] heparin 1000 units/mL, 1-5 mL, intracatheter, ONCE, Pack dialysis catheter with the volume of catheter plus 0.25 mL
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

- **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

- **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

- **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](http://www.ohsuknight.com/infusionorders)