ADULT AMBULATORY INFUSION ORDER

Vaccines

Page 1 of 2

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.

NURSING ORDERS:

1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

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 (ENGERIX-B) 20 mcg/mL, intramuscular, 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-diptheria toxoid conjugate vaccine (MENACTRA) 0.5 mL, intramuscular, ONCE
☐ Pneumococcal (23 valent) polysaccharide vaccine (PNEUMOVAX) 0.5 mL, intramuscular, ONCE
☐ Varicella-zoster (recombinant) vaccine (SHINGRIX) 0.5mL, intramuscular, ONCE
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