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. Labs (H&H or CBC) must be drawn within 30 days prior to phlebotomy.
3. Ferritin must be drawn within 90 days prior to phlebotomy.
   a. If phlebotomy parameters are based on Ferritin level, H/H results and parameters must be ordered at each visit to rule out anemia.

LABS:
□ Hemoglobin & Hematocrit, Routine, ONCE, every visit
□ Ferritin (serum), routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
□ Labs already drawn. Date: ____________

NURSING ORDERS:
1. VITAL SIGNS – Pre-phlebotomy and orthostatic vital signs prior to discharge.
2. TREATMENT PARAMETERS:
   a. Perform phlebotomy if:
      i. Hgb is greater than or equal to: ____________ mg/dL
         OR
      ii. Hct is greater than or equal to: ____________ %
   b. Ferritin goal is: ___________________________________
3. TREATMENT PARAMETERS – Notify provider if vital signs abnormal.
4. Discharge 30 minutes after phlebotomy complete and after orthostatic vital signs are completed.
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

THERAPEUTIC PHLEBOTOMY:

Phlebotomize ______ mL of blood as directed (no more than 500 mL at one time).

Interval: (must check one)
□ Once
□ Weekly
□ Every other week
□ Once monthly
AS NEEDED MEDICATIONS:
1. Sodium chloride (NS) 0.9% bolus, 1000 mL, intravenous, AS NEEDED x 1 dose, if after phlebotomy standing SBP drops by greater than or equal to 20 points from reclined SBP OR standing DBP drops by greater than or equal to 10 points from reclined DBP and symptomatic (pallor, diaphoresis, nausea, dizziness, fainting). Contact provider if additional orders needed.

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