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:

Analgesics:
☐ acetaminophen (TYLENOL) tablet, ____ mg, oral, ONCE
☐ HYDROmorphine (DILAUDID) injection, _____ mg, intravenous, ONCE
☐ ibuprofen (ADVIL) tablet, ______ mg, oral, ONCE
☐ ketorolac (TORADOL) injection, ______ mg, intravenous, ONCE
☐ morphine injection, _____ mg, intravenous, ONCE

Interval: (must check one)
☐ ONCE
☐ Daily x _____ doses
☐ Every _______ days x _____ doses

Diuretics:
☐ chlorothiazide (DIURIL) injection, _______ mg, intravenous, ONCE
☐ furosemide (LASIX) injection, ________ mg, intravenous, ONCE (doses over 80 mg will be dispensed in a bag)

Interval: (must check one)
☐ ONCE
☐ Daily x _____ doses
☐ Every _______ days x _____ doses

Octreotides:
☐ octreotide, microspheres (SANDOSTATIN LAR) 20 mg, intramuscular, ONCE
☐ octreotide, microspheres (SANDOSTATIN LAR) 30 mg, intramuscular, ONCE

Interval: (must check one)
☐ ONCE
☐ Daily x _____ doses
<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Route</th>
<th>Interval (must check one)</th>
<th>(Pharmacist to confirm availability)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calcitriol (CALCIJEX)</td>
<td>mcg</td>
<td>intravenous</td>
<td>ONCE</td>
<td></td>
</tr>
<tr>
<td>Cyanocobalamin (VITAMIN B-12)</td>
<td>mcg, subcutaneous</td>
<td>ONCE</td>
<td>Daily x _____ doses</td>
<td></td>
</tr>
<tr>
<td>Desmopressin (DDAVP)</td>
<td>mcg in NaCl 0.9% 50</td>
<td>intravenous</td>
<td>ONCE</td>
<td></td>
</tr>
<tr>
<td>Dihydroergotamine (DHE)</td>
<td>mg</td>
<td>intravenous</td>
<td>ONCE</td>
<td></td>
</tr>
<tr>
<td>Fat emulsion (INTRALIPID)</td>
<td>mL</td>
<td>intravenous</td>
<td>ONCE</td>
<td></td>
</tr>
<tr>
<td>HydroXYzine (VISTARIL)</td>
<td>mg</td>
<td>intramuscular</td>
<td>ONCE</td>
<td></td>
</tr>
<tr>
<td>Meperidine (DEMEROL)</td>
<td>mg</td>
<td>intravenous</td>
<td>ONCE</td>
<td></td>
</tr>
<tr>
<td>Other (drug, dose, route)</td>
<td></td>
<td></td>
<td></td>
<td>(Pharmacist to confirm availability)</td>
</tr>
</tbody>
</table>

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: ___________

Central Intake:
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