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.

LABS:

☐ ________________________________

☐ ________________________________

NURSING COMMUNICATIONS:

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

☐ ________________________________

☐ ________________________________

PRE-MEDICATIONS:

☐ ________________________________

☐ ________________________________

MEDICATIONS:

☐ ________________________________

☐ ________________________________

PRN MEDICATIONS:

☐ ________________________________

☐ ________________________________
HYPERSENSITIVITY MEDICATIONS:

☐ Yes / ☐ No (select one)

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.

2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

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](http://www.ohsuKnight.com/infusionorders)