ADULT AMBULATORY INFUSION ORDER
Factor, Antithrombotics, and Albumin

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ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

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:

**Factor:** *(Pharmacist will use most recent weight and round dose to the nearest vial)*
- [ ] Antihemophilic Factor – VWF (HUMATE-P) _________ units/kg, intravenous, ONCE (dosing based on international units of vWF)
- [ ] Antihemophilic Factor VIII (recomb) (RECOMBINATE) _______ units/kg, intravenous, ONCE

**Interval:** *(must check one)*
- [ ] Once
- [ ] Daily x _____ doses
- [ ] Every _____ days x _____ doses

**Antithrombotics:**
- [ ] Enoxaparin _____ mg, subcutaneous, ONCE (pharmacist will round dose during order verification)
- [ ] Fondaparinux _________ mg, subcutaneous, ONCE

**Interval:** *(must check one)*
- [ ] Once
- [ ] Daily x _____ doses
- [ ] Every _____ days x _____ doses

**Albumin:** *(pharmacist will round dose during order verification)*
- [ ] Albumin 5% _____ grams/kg = _______ grams, intravenous, ONCE
- [ ] Albumin 25% ___ grams/kg = _______ grams, intravenous, ONCE

**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