ADULT AMBULATORY INFUSION ORDER

Cupric Chloride (COPPER) Infusion

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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. This product contains aluminum. Use caution with prolonged infusions in patients with renal insufficiency.
3. Use with caution in patients with significant cholestasis or hepatic dysfunction.
4. Cupric chloride is not recommended for patients with Wilson's Disease.
5. A serum copper level must be obtained within 30 days prior to starting treatment.

LABS:

- CMP, Routine, ONCE, every ______ (visit)(days)(weeks)(months) – Circle One

NURSING ORDERS:

1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
2. Treatment Parameter: Hold copper chloride and notify provider if serum copper greater than 80 mcg/dL prior to initial treatment.
3. Treatment Parameter: Hold copper chloride and notify provider if total bilirubin greater than 1.5 x ULN, or alkaline phosphatase greater than 10 x ULN.

MEDICATIONS: (must check one)

cupric chloride (COPPER) 2 mg in sodium chloride 0.9% 100 mL, IV, ONCE, over 2 hours

Interval: (must check one)

- Once
- Daily x _____ doses
- Other: ________________________________
HYPERSENSITIVITY MEDICATIONS:

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 (Adrenaline) 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