ADULT AMBULATORY INFUSION ORDER
Alteplase (t-PA) Infusion for Dialysis Catheters

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**

NURSING ORDERS:
1. Aspirate 3 mL of blood from each dialysis lumen to remove high dose heparin prior to flushing
2. Refer to nursing and IV therapy guidelines for care of central venous catheters
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

MEDICATIONS:

INFUSION ORDERS

LUMEN #1
☐ alteplase (ACTIVASE) 2 mg in sodium chloride 0.9% 100 mL, intracatheter, ONCE over 4 hours as needed for occluded dialysis catheter lumen (Maximum of 4 mg total in all lumens)

LUMEN #2
☐ alteplase (ACTIVASE) 2 mg in sodium chloride 0.9% 100 mL, intracatheter, ONCE over 4 hours as needed for occluded dialysis catheter lumen (Maximum of 4 mg total in all lumens)

POST INFUSION ORDERS

LUMEN #1
☐ alteplase (ACTIVASE) 2 mg, intracatheter, ONCE, Label dressing "TPA dwell" with date, time, and RN initials

OR
☐ heparin 1000 units/mL, 1-5 mL, intracatheter, ONCE, Pack dialysis catheter with the volume of catheter plus 0.25 mL
LUMEN #2
- ☐ alteplase (ACTIVASE) 2 mg, intracatheter, ONCE, Label dressing "TPA dwell" with date, time, and RN initials
- OR
- ☐ heparin 1000 units/mL, 1-5 mL, intracatheter, ONCE, Pack dialysis catheter with the volume of catheter plus 0.25 mL

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