Oregon Health & Science University Hospital and Clinics Provider's Orders PO7071 ADULT AMBULATORY INFUSION ORDER **Central Line Maintenance** Page 1 of 3	ACCOUNT NO. MED. REC. NO. NAME BIRTHDATE *Patient Identification*

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. Central line maintenance practices at OHSU do not routinely include use of heparin 500 unit/5mL lock(s) and this option is NOT indicated in current policy. If patient requires use of heparin 500 unit/5mL lock due to historical practice and continued patient preference, then provider MUST select order to indicate use.
3. CHO & CHH/PPV locations ONLY: Central line maintenance practices at OHSU do not routinely include use of heparin 100 unit/mL 5 mL lock(s) and this option is NOT indicated in current policy. If patient requires use of heparin 100 units/mL 5 mL lock due to historical practice and continued patient preference, the provider MUST add order to plan to indicate use.

NURSING ORDERS:

1. OK to use line.
2. Dressing changes per OHSU nursing policy Catheter-related Bloodstream Infection (CLABSI) Prevention (HC-NSG-260-PRO).
3. Implanted Port flushes every 60 to 90 days per OHSU nursing policy Vascular Access Flushing (HC-NSG-236-PRO).
4. PICC / Midline / External Central Venous Catheters flushes every 7 days per OHSU nursing policy Vascular Access Flushing (HC-NSG-236-PRO).
5. The use of alteplase for lines with sluggish or no blood return per Nursing: Alteplase Central Line De-clot - Job Aid (HC-NSG-307-FMT). If unable to establish patency after 2 doses, contact the provider.
6. OK to access port for labs.
7. Remove PICC – Pull PICC/Midline on _____ (specify date).
8. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

MEDICATIONS:

☐ alteplase (CATHFLO ACTIVASE): 2 mg INTRACATHETER, AS NEEDED for no blood return, occluded line or sluggish flush x 2 per lumen.
Instill tPA into the line, allow to dwell for 30 minutes. Assess for blood return, If no blood return, allow to dwell for additional 90 minutes. If no blood return after 120 minutes, remove current dose and may redose x1. After 2 doses contact MD for additional orders. Refer to Nursing: Alteplase Central Line De-clot - Job Aid (HC-NSG-307-FMT).

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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 (ADRENALIN) injection, 0.5 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**: _____

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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