



Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071



ADULT AMBULATORY INFUSION ORDER

Blank Plan

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.

LABS:

☐ _____

☐ _____

NURSING COMMUNICATIONS:

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

☐ _____

☐ _____

PRE-MEDICATIONS:

☐ _____

☐ _____

MEDICATIONS:

☐ _____

☐ _____

PRN MEDICATIONS:

☐ _____

☐ _____



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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:** _____



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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