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

PO9031

ADULT AMBULATORY INFUSION ORDER

Dialysis Catheter TPA (Alteplase)

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****

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) 4 mg in sodium chloride 0.9% 100 mL, intracatheter, ONCE over 2 hours as needed for occluded dialysis catheter lumen (Maximum of 8 mg total in all lumens)

LUMEN #2

☐ alteplase (ACTIVASE) 4 mg in sodium chloride 0.9% 100 mL, intracatheter, ONCE over 2 hours as needed for occluded dialysis catheter lumen (Maximum of 8 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

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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:** _____

Please check the appropriate box for the patient's preferred clinic location:

☐ **Hillsboro Medical Center**
Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123
Phone number: (503) 681-4124
Fax number: (503) 681-4120

☐ **Adventist Health Portland**
Infusion Services
10123 SE Market St
Portland, OR 97216
Phone number: (503) 261-6631
Fax number: (503) 261-6756

☐ **Mid-Columbia Medical Center**
Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
Fax number: (541) 296-7610