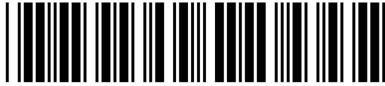
Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO9031


ADULT AMBULATORY INFUSION ORDER

Port Care

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 – Labs will be drawn at same interval as port care unless otherwise specified

- ☐ ___________________, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ ___________________, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ ___________________, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One

NURSING ORDERS:

1. **Flush Port, every ________ weeks**
2. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes

MEDICATIONS – Check all that apply

- ☐ lidocaine 10 mg/mL (1%) injection, 0.1 mL, intradermal, AS NEEDED for patient comfort
- ☐ heparin 100 units/mL flush, 500 units (5 mL), intracatheter, AS NEEDED for port patency
- ☐ sodium chloride 0.9% flush, 10 mL, intracatheter, AS NEEDED for port patency
- ☐ alteplase (CATHFLO ACTIVASE) injection, 2 mg, intracatheter, AS NEEDED for catheter occlusion

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

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