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

PO9031

ADULT AMBULATORY INFUSION ORDER

Other Therapy

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. Medications may require a 24 hour turn-around time before they are available at specific clinic locations. Please consider contacting the clinic pharmacist to determine availability prior to scheduling patient.

MEDICATIONS:

Analgesics:

- ☐ acetaminophen (TYLENOL) tablet, _____ mg, oral, ONCE
- ☐ HYDROmorphone (DILAUDID) injection, _____ mg, intravenous, ONCE
- ☐ ibuprofen (ADVIL) tablet, _____ mg, oral, ONCE
- ☐ ketorolac (TORADOL) injection, _____ mg, intravenous, ONCE
- ☐ morphine injection, _____ mg, intravenous, ONCE

Interval: ***(must check one)***

- ☐ ONCE
- ☐ Daily x _____ doses
- ☐ Every _____ days x _____ doses

Diuretics:

- ☐ chlorothiazide (DIURIL) injection, _____ mg, intravenous, ONCE
- ☐ furosemide (LASIX) injection, _____ mg, intravenous, ONCE (doses over 80 mg will be dispensed in a bag)

Interval: ***(must check one)***

- ☐ ONCE
- ☐ Daily x _____ doses
- ☐ Every _____ days x _____ doses

Octreotides:

- ☐ octreotide, microspheres (SANDOSTATIN LAR) 20 mg, intramuscular, ONCE
- ☐ octreotide, microspheres (SANDOSTATIN LAR) 30 mg, intramuscular, ONCE

Interval: ***(must check one)***

- ☐ ONCE
- ☐ Daily x _____ doses

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☐ **Calcitriol (CALCIJEX)** injection, _____ mcg, intravenous, ONCE
Interval: *(must check one)*
- ☐ ONCE
- ☐ Daily x _____ doses

☐ **Cyanocobalamin (VITAMIN B-12)** injection, 1000 mcg, subcutaneous, ONCE
Interval: *(must check one)*
- ☐ ONCE
- ☐ Daily x _____ doses

☐ **Desmopressin (DDAVP)** _____ mcg in NaCl 0.9% 50 mL, intravenous, ONCE
Interval: *(must check one)*
- ☐ ONCE
- ☐ Daily x _____ doses

☐ **Dihydroergotamine (DHE)** injection, 1 mg, intravenous, ONCE
Interval: *(must check one)*
- ☐ ONCE
- ☐ Daily x _____ doses
- ☐ Every _____ hours x _____ doses

☐ **Fat emulsion (INTRALIPID)** 20%, _____ mL, intravenous, ONCE (100, 250, or 500 mL)
Interval: *(must check one)*
- ☐ ONCE
- ☐ Daily x _____ doses

☐ **HydrOXYzine (VISTARIL)** injection, _____ mg, intramuscular, ONCE
Interval: *(must check one)*
- ☐ ONCE

☐ **Meperidine (DEMEROL)** injection, _____ mg, intravenous, ONCE
Interval: *(must check one)*
- ☐ ONCE

☐ Other (drug, dose, route): _____
Interval: *(must check one)* *(Pharmacist to confirm availability)*
- ☐ ONCE
- ☐ Daily x _____ doses
- ☐ Every _____ days x _____ doses
- ☐ Every _____ weeks x _____ doses

NURSING ORDERS:

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

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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:

☐ TUALITY HEALTHCARE
An OHSU Partner

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

☐ MCMC
MID-COLUMBIA MEDICAL CENTER
A Planetree Patient-Centered Hospital

Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
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