



ADULT AMBULATORY INFUSION ORDER
3/2023
PICC Line Placement

NAME:
BIRTHDATE:
INSURANCE:
PROVIDER NAME:
CLINIC NAME and Phone number:

Patient identification

Weight: _____ kg Height: _____ cm Allergies: _____ Diagnosis Code: _____

Treatment Start Date: _____

****If treatment not started within 90 days, new orders with updated date/signature will be required.****

GUIDELINES FOR ORDERING:

- 1) Patient name and date of birth must be on EACH page of this order form. This form will be returned if any left blank.
- 2) Send FACE SHEET and complete copy of INSURANCE information. Send H&P or most recent chart note, must be within the past 12 months.
- 3) PICC line placement is not available at all OPI locations, see end of form for locations & contact information.

Date of next treatment this line is needed for: _____.

REASON FOR LINE:

- Longterm antibiotics
- TPN
- Chemotherapy
- Poor venous access
- Caustic/irritants
- Central/PICC replacement. If line needing replacement has not been removed yet, this order allows OPI to remove the line needing replacement prior to placing a new one.
- Other: _____.

ANTIBIOTICS Patients only:

- OPI to give FIRST dose of antibiotics, then home infusion to provide all remaining doses. If selected, must include order for one time dose of antibiotics with this form if not in Epic.
- OPI will only place line. Home infusion will provide all doses.

TYPE OF LINE:

- Midline, single lumen.
- PICC line, number of lumens & power injectable per RN discretion.

PICC LINE CONSENT:

- I have discussed the risks versus benefits of PICC placement, as well as alternatives with the patient. Patient understands and agrees to procedure.

Standard included Nursing Orders:

- ✓ Inpatient consult to IV team.
- ✓ Verify line placement per ministry protocol before use; by radiologist.
- ✓ Dressing change per standard of care.
- ✓ Sodium chloride 0.9% (NS) flush
- ✓ RN may place order for alteplase to de clot catheter per facility guidelines.
- ✓ May draw labs from line.
- ✓ PICC line precautions: do not use PICC extremity for blood pressures, peripheral IV sites or venipuncture.



NAME:
 BIRTHDATE:
 INSURANCE:
 PROVIDER NAME:
 CLINIC NAME and Phone number:

Patient identification

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.

My physician license Number is # _____ and I am acting within my scope of practice and authorized by law to order infusion of the medications and blood products described above for the patient identified on this form.

Provider's printed name: _____

Provider's signature: _____

Date: _____

Please complete the following intake questions.

Mobility status

- Independent
- Walker
- Wheelchair
- Fully dependent

Bariatric needs

- Yes, briefly describe _____
- No

Transportation concerns

- Yes, briefly describe _____
- No

Interpreter Service required

- Yes, language _____
- No

Outpatient Infusion Services Intake Team:

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

- PORTLAND** Phone-503-215-6046 Fax-503-487-3582
- MEDFORD** Phone-541-732-7000 Fax-541-732-3939
- SEASIDE (Pre-Op)** Phone- 503-717-7239 Fax- Call for fax #
- NEWBERG (SSU)** Phone-503-537-1450 Fax-503-537-1449
- ST VINCENTS** Contact Interventional Radiology department