



ADULT AMBULATORY INFUSION ORDER
3/2023
PICC/Port Maintenance

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. Otherwise, orders are valid for 1 year from signature date.****

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.

PORT:

- Dressing change & port flush every 4 weeks.
- Dressing change & port flush every _____ weeks.

PICC LINE/GROSHONG:

- Dressing change & flush each lumen weekly.

Optional LABS:

- Lab: _____, frequency: _____.
- Lab: _____, frequency: _____.
- Lab: _____, frequency: _____.
- Lab: _____, frequency: _____.

PRN MEDS:

- Alteplase (cathflo activase) injection 2 mg, for clotted or sluggish line.

Standard included Nursing Orders:

- Dressing change per policy.
- Sodium chloride 0.9% (NS) flush.
- May use/access CVC line and give 500 units (5ml) heparin injection for central line care.

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: _____



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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
- WILLAMETTE FALLS** Phone-503-215-6046 Fax-503-487-3582
- MEDFORD** Phone-541-732-7000 Fax-541-732-3939
- HOOD RIVER** Phone-541-387-6445 Call for fax #
- SEASIDE** Phone-503-717-7650 Fax-503-470-3146
- NEWBERG** Phone-503-537-6040 Fax-503-205-8720