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

PO9031

ADULT AMBULATORY INFUSION ORDER

Capped Catheter Flush

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****

MEDICATIONS:

Central Catheters:

☐ **heparin (100 units/mL) syringe: 500 units/5 mL IV flush, AS NEEDED x _____ lumens**
Flush with 5 mL after each use or once daily and as needed to maintain patency
- Hickman/Broviac Catheters
- Central Venous Catheters – percutaneous open ended
- Power PICC or Arrow PICC
- Midline – open ended

☐ **sodium chloride 0.9%: 10 mL IV flush, AS NEEDED x _____ lumens**
Flush valved catheters with 10 mL after each use or weekly and as needed to maintain patency. Flush with 10 mL prior to blood draw and 20 mL following blood draw.
- Groshong, Groshong Midline, Groshong Implanted Port
- PICC, Power PICC
- PASC CVC

☐ **sodium chloride 0.9%: 10 mL IV flush**
- and -
heparin (100 units/mL) IV syringe: 500 units/5mL IV flush, AS NEEDED x _____ lumens
Flush Neostar with 10 mL sodium chloride followed by 5 mL heparin after each use or three times weekly and as needed to maintain patency. Flush with 10 mL sodium chloride prior to blood draw and 20 mL sodium chloride following blood draw, followed by 5 mL heparin.

☐ **alteplase (CATHFLO ACTIVASE): 2 mg INTRACATHETER, AS NEEDED x _____ lumens**
Instill for no blood return, occluded line, or sluggish flush

Peripheral Lines:

☐ **sodium chloride 0.9%: 2 mL IV flush, AS NEEDED**
Flush peripheral line with 2 mL after each use or once daily and as needed to maintain patency.

Other:

☐ **heparin (10 units/mL: 50 units/5 mL IV flush, AS NEEDED x _____ lumens**
☐ **heparin (1 unit/mL): 5 units/5 mL IV flush, AS NEEDED x _____ lumens**

Oregon Health & Science University Hospital and Clinics Provider's Orders ADULT AMBULATORY INFUSION ORDER **Capped Catheter Flush** Page 2 of 2	ACCOUNT NO. MED. REC. NO. NAME BIRTHDATE *Patient Identification*

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

NURSING ORDERS:

1. Refer to nursing and IV therapy guidelines for care of central venous catheters.
2. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

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
Fax number: (541) 296-7610