TUALITY HEALTHCARE
An OHSU Partner

Tuality Hematology Oncology/Infusion clinic
Phone: 503-681-4124/ Fax: 503-681-4120

ADULT AMBULATORY INFUSION ORDER
Port Care

PATIENT NAME:

BIRTHDATE:

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

Weight: _____kg **Height:** _____cm

Allergies: _____**Diagnosis Code:**_____

****This plan will expire after 365 days at which time a new order will need to be placed****

MEDICATIONS:

- Lidocaine 0.1ml, 10mg/ml (1%), Intradermal, AS NEEDED to site for patient comfort
- Heparin 500 units (5ml), 100 units/ml ,Intra-catheter, AS NEEDED, to maintain patency
- Sodium Chloride 0.9% 10ml, Intra-catheter, AS NEEDED, to maintain patency.
- Alteplase (Cathflo Activase) 2 mg, Intra-catheter, AS NEEDED, for catheter occlusion

INTERVAL:

☐ Flush port every _____ weeks

LABS: Labs will be drawn at same interval as Port care unless otherwise specified.

☐ _____

☐ _____

NURSING COMMUNICATIONS:

1. Nursing communication order, every visit: Manage line per Tuality Vascular Access Flushing Procedure (Could include flushes with NS, heparin 100 units/mL)
2. Nursing communication order, every visit: Manage central venous catheter per Tuality De-clotting Procedure for Vascular Access Policy (could include r-tpa (alteplase) 2mg/2ml)
3. Nursing communication order, every visit: Manage site access per Tuality PICC and Central Venous Access Site Assessment and Dressing Changes Policy

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: ☐ _____
My physician license Number is # _____ ; 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**: _____