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

PO9031

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ADULT AMBULATORY INFUSION ORDER

Alteplase (t-PA) Infusion for Dialysis Catheters

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****

NURSING ORDERS:

1. Aspirate 3 mL of blood from each dialysis lumen to remove high dose heparin prior to flushing
2. Refer to nursing and IV therapy guidelines for care of central venous catheters
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

MEDICATIONS:

INFUSION ORDERS

LUMEN #1

☐ alteplase (ACTIVASE) 2 mg in sodium chloride 0.9% 100 mL, intracatheter, ONCE over 4 hours as needed for occluded dialysis catheter lumen (Maximum of 4 mg total in all lumens)

LUMEN #2

☐ alteplase (ACTIVASE) 2 mg in sodium chloride 0.9% 100 mL, intracatheter, ONCE over 4 hours as needed for occluded dialysis catheter lumen (Maximum of 4 mg total in all lumens)

POST INFUSION ORDERS

LUMEN #1

☐ alteplase (ACTIVASE) 2 mg, intracatheter, ONCE, Label dressing "TPA dwell" with date, time, and RN initials

OR

☐ heparin 1000 units/mL, 1-5 mL, intracatheter, ONCE, Pack dialysis catheter with the volume of catheter plus 0.25 mL

LUMEN #2

☐ alteplase (ACTIVASE) 2 mg, intracatheter, ONCE, Label dressing "TPA dwell" with date, time, and RN initials

OR

☐ heparin 1000 units/mL, 1-5 mL, intracatheter, ONCE, Pack dialysis catheter with the volume of catheter plus 0.25 mL

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HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

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 indicate the patient's preferred clinic location below**

☐	**HILLSBORO MEDICAL CENTER** 364 SE 8th Ave, Medical Plaza Suite 108B, Hillsboro, OR 97123	Phone (503) 681-4124 Fax (503) 681-4120
☐	**ADVENTIST HEALTH – PORTLAND** Infusion Services, 10123 SE Market St, Portland, OR 97216	Phone (503) 261-6631 Fax (503) 261-6756
☐	**ADVENTIST HEALTH – COLUMBIA GORGE** Celilo Cancer Center, 1800 E 19th St, The Dalles, OR 97058	Phone (541) 296-7585 Fax (541) 296-7610