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

PO9031

ADULT AMBULATORY INFUSION ORDER

# Alteplase (t-PA) Infusion for Central Venous Catheters



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****

## GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. This plan is intended for patients with line access challenges after all other delegation protocols have been attempted.

## 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.

## MEDICATIONS:

☐ alteplase (ACTIVASE) 2 mg in sodium chloride 0.9% infusion, 100 mL, intracatheter, ONCE over 4 hours (Maximum of 4 mg total in all lumens)

## 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

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| **Oregon Health & Science University Hospital and Clinics Provider's Orders**<br><br>ADULT AMBULATORY INFUSION ORDER<br>**Alteplase (t-PA) Infusion for Central Venous Catheters**<br>Page 2 of 2 | ACCOUNT NO.<br>MED. REC. NO.<br>NAME<br>BIRTHDATE<br><br>*Patient Identification* |

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**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**

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