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

PO7071

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.

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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**: _____

Central Intake:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient's preferred clinic location:

☐ **Beaverton**
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

☐ **NW Portland**
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

☐ **Gresham**
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

☐ **Tualatin**
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders