Factor, Antithrombotics, and Albumin

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. Medications may require a 24 hour turn-around time before they are available at specific clinic locations. Please consider contacting the clinic pharmacist to determine availability prior to scheduling patient.

MEDICATIONS:

Factor: *(Pharmacist will use most recent weight and round dose to the nearest vial)*

- ☐ Antihemophilic Factor – VWF (HUMATE-P) _____ units/kg, intravenous, ONCE (dosing based on international units of vWF)
- ☐ Antihemophilic Factor VIII (recomb) (RECOMBINATE) _____ units/kg, intravenous, ONCE

Interval: *(must check one)*

- ☐ Once
- ☐ Daily x _____ doses
- ☐ Every _____ days x _____ doses

Antithrombotics:

- ☐ Enoxaparin _____ mg, subcutaneous, ONCE (pharmacist will round dose during order verification)
- ☐ Fondaparinux _____ mg, subcutaneous, ONCE

Interval: *(must check one)*

- ☐ Once
- ☐ Daily x _____ doses
- ☐ Every _____ days x _____ doses

Albumin: *(pharmacist will round dose during order verification)*

- ☐ Albumin 5% _____ grams/kg = _____ grams, intravenous, ONCE
- ☐ Albumin 25% _____ grams/kg = _____ grams, intravenous, ONCE

NURSING ORDERS:

1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

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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**: _____

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