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

ADULT AMBULATORY INFUSION ORDER

Vaccines

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.

NURSING ORDERS:

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

MEDICATIONS:

Vaccines:

- ☐ Diphtheria-acellular pertussis-tetanus vaccine (BOOSTRIX) 0.5 mL, intramuscular, ONCE
- ☐ Haemophilus b polysac-tetanus toxoid vaccine (ActHIB) 0.5 mL, intramuscular, ONCE
- ☐ Hepatitis B vaccine (ENGERIX-B) 20 mcg/mL, intramuscular, ONCE
- ☐ Influenza vaccine 0.5 mL, intramuscular, ONCE (for 3 years of age and older)
- ☐ Influenza HD vaccine 0.5 mL, intramuscular, ONCE (for 65 years of age and older)
- ☐ Meningococcal oligosaccharide diptheria conjugate vaccine (MENVEO) 0.5 mL, intramuscular, ONCE
- ☐ Pneumococcal (20 valent) conjugate vaccine (PREVNAR 20) 0.5 mL, intramuscular, ONCE
- ☐ Varicella-zoster (recombinant) vaccine (SHINGRIX) 0.5 mL, intramuscular, ONCE
- ☐ Meningococcal group B vaccine (BEXSERO) injection 0.5 mL, intramuscular, ONCE

OHSU Health — Oregon Health & Science University Hospital and Clinics Provider's Orders ADULT AMBULATORY INFUSION ORDER **Vaccines** 	ACCOUNT NO. MED. REC. NO. NAME BIRTHDATE *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 check the appropriate box for the patient's preferred clinic location:

☐ **Hillsboro Medical Center**
Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123
Phone number: (503) 681-4124
Fax number: (503) 681-4120

☐ **Adventist Health Portland**
Infusion Services
10123 SE Market St
Portland, OR 97216
Phone number: (503) 261-6631
Fax number: (503) 261-6756

☐ **Mid-Columbia Medical Center**
Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
Fax number: (541) 296-7610