LOWER UMPQUA HOSPITAL
OUTPATIENT NURSING DEPARTMENT
600 Ranch Road, Reedsport, OR 97467
For Referrals: (541) 271-2163 – Press #3 (all other services) then press # 2 (Referrals)
For Outpatient Nursing: (541) 271-2171 ext. 5205
FAX: (541) 271-5433

PORT-A-CATH FLUSH

Patient Name _____ **DOB** _____

Patient Phone # _____ **Patient Weight (Kg)** _____ **Patient Height (cm):** _____

Patient Allergies _____

Provider _____ **NPI#** _____

ICD-10 Code (REQUIRED) _____ **J Code** _____

Primary Diagnosis _____

Secondary Diagnosis _____

Duration (or # of treatments): _____ **Anticipated Infusion Date** _____

SINGLE PORT-A-CATH FLUSH

☐ PORT-A-CATH SINGLE PORT
- ☑ May Access PORT-A-CATH following Radiology confirmation of catheter tip in superior vena cava (SVC)
- ☑ Obtain 1 View CXR for confirmation of catheter tip placement if not already obtained in last year

MEDICATIONS

☑ **alteplase** *(CATHFLO ACTIVASE)* 2 mg IVP ONCE PRN Catheter Occlusion.
*May repeat **x** 1 dose after 2 hours of administration if catheter still occluded.*

☑ **0.9% sodium chloride** flush **–**10 mL syringe IVP 20 mL Every _____ weeks

******Saline before heparin flush******

☑ **heparin** flush 500 units = 5 mL IVP Every _ weeks

Notify
- Provider should be consulted **before** heparinization of a line when the patient's platelet count **is 50,000 or less**

LABS

Labs to be drawn: _____

Continued next page ➔

Date _____ Time _____ Provider Signature _____

"Statement of Responsibility of Parties: referring Prescriber agrees that in referring patients to Lower Umpqua Hospital Outpatient Nursing Department, the responsibility for the care related to these Outpatient Nursing Therapy Plan orders, as well as administration of any 340B drugs, remains with Lower Umpqua Hospital."

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PORT-A-CATH FLUSH

Patient Name _____ **DOB** _____

DUAL PORT-A-CATH FLUSH

☐ PORT-A-CATH DUAL PORT
- ☑ May Access PORT-A-CATH following Radiology confirmation of catheter tip in superior vena cava (SVC)
- ☑ Obtain 1 View CXR for confirmation of catheter tip placement if not already obtained in last year

MEDICATIONS
- ☑ **alteplase** *(CATHFLO ACTIVASE)* 2 mg IV ONCE PRN Catheter Occlusion
  *May repeat **x** 1 dose in each line after 2 hours of administration in catheter(s) if still occluded*
- ☑ **0.9% sodium chloride** flush 10 mL syringe IVP 20 mL Every _____ weeks - **Lateral**
- ☑ **0.9% sodium chloride** flush syringe IVP 20 mL Every _____ weeks - **Medial**

******Saline before heparin flush******

- ☑ **heparin** Flush 500 units = 5 mL IVP Every _____ weeks – **Lateral**
- ☑ **heparin** Flush 500 units = 5 mL IVP Every _____ weeks – **Medial**

Notify Provider
- Provider should be consulted **before** heparinization of a line when the patient's platelet count **is 50,000 or less**

LABS

Labs to be drawn: _____

Date _____ Time _____ Provider Signature _____

"Statement of Responsibility of Parties: referring Prescriber agrees that in referring patients to Lower Umpqua Hospital Outpatient Nursing Department, the responsibility for the care related to these Outpatient Nursing Therapy Plan orders, as well as administration of any 340B drugs, remains with Lower Umpqua Hospital."