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

OUTPATIENT THERAPY ORDERS (ADULT)

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** _____

THERAPY PLAN / DRUG NAME: _____

INSTRUCTIONS TO PROVIDER:

- ***Please ensure insurance authorization has been initiated.***
- *Lab orders should NOT be included on this form – place orders via usual method.* ***Lab monitoring is the responsibility of the ordering Provider.***
- *This plan will expire* ***after 365 days****, at which time new orders will need to be placed.*

MEDICATIONS *(Drug name / dose / route / frequency / interval)*:

_____

_____

_____

ORDERING GUIDELINES:

☒ Send **FACE SHEET and H&P or most recent chart note**

_____

PRE-MEDICATIONS *(Drug name / dose / route) Administer 30 to 60 minutes prior to each infusion*:

_____

_____

_____

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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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OUTPATIENT THERAPY ORDERS (ADULT)

Patient Name _____ **DOB** _____

LAB NURSE DRAW *(ONLY use for ordering labs that must be done the day of infusion)*:

_____

_____

_____

TREATMENT PARAMETERS:

_____

_____

_____

_____

NURSING ORDERS:

_____

_____

_____

_____

HYDRATION / MAINTENANCE TKO:

- ☒ **0.9% sodium chloride** infusion, 25 mL/hour, IV **x** 1 PRN per policy - flush/hydration/main bag/TKO
- ☐ **dextrose 5%** infusion, 25 mL/hour, IV **x** 1 PRN per policy - flush/hydration/main bag/TKO

LINE CARE MAINTENANCE:

- ☒ Follow facility policies and procedures for all vascular access maintenance with appropriate flush solutions, de-clotting (**alteplase**), and/or dressing changes.
- ☒ **alteplase** *(CATHFLO ACTIVASE)* injection 2 mg/2 mL, intra-catheter **x** 1 PRN de-clotting per policy for 2 doses
- ☒ **heparin, porcine (Preservative Free)** 100 units/mL IV syringe, 500 units, intra-catheter **x** 1 PRN line care
- ☒ **0.9% sodium chloride** flush, 10 to 30 mL IV; See policy and/or medication admin instructions, flush as needed
- ☒ If applicable, may remove PICC line at the completion of course of therapy

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Date _____ Time _____ Provider Signature _____

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OUTPATIENT THERAPY ORDERS (ADULT)

Patient Name _____ **DOB** _____

EMERGENCY MEDICATIONS FOR HYPERSENSITIVITY / INFUSION REACTION:

** *Itching, hives, fever* **

- ☒ **STOP MEDICATION INFUSION if allergic reaction occurs**
- ☒ Establish IV access and infuse **0.9% sodium chloride** 500 mL at 25 mL/hour PRN Hypersensitivity / Allergic reaction
- ☒ VS Q15 minutes **x** 4 and PRN
- ☒ **acetaminophen** *(TYLENOL)* 650 mg PO Q4HRS PRN Hypersensitivity / Allergic Reaction.
- ☒ **diphenhydramine** *(BENADRYL)* 25 MG IVP PRN Hypersensitivity / Allergic Reaction **x** 1 dose. May repeat **x** 1 ***{Maximum dose = 50 mg}***
- ☒ **NOTIFY** Provider of Hypersensitivity / Allergic Reaction
- ☒ **hydrocortisone** 100 mg IVP PRN Hypersensitivity / Allergic Reactions **x** 1 dose if reaction continues and is not relieved by maximum dose of **Diphenhydramine**

ANAPHYLAXIS REACTION

** *Wheezing, Dyspnea, Hypotension, Angioedema, Chest pain, Tongue swelling* **

- ☒ Transfer to Emergency Department (ED) as needed, and **NOTIFY** Provider
- ☒ **epinephrine** 0.3 mg IM PRN anaphylaxis **x** 1 dose

Date _____ Time _____ Provider Signature _____

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