Legacy Day Treatment Unit
Provider’s Orders

Adult Ambulatory Infusion Order
BLANK TEMPLATE

Patient Name: 
Date of Birth: 
Med. Rec. No (TVC MRN Only): 

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Anticipated Start Date: ___________ Patient to follow up with provider on date: ___________

***This plan will expire after 365 days, unless otherwise specified below***

Orders expire: ____________________

Weight: ___________ kg Height: ___________ cm

Allergies: __________________________

Diagnosis: __________________________ Diagnosis Code: ___________

GUIDELINES FOR PRESCRIBING:

1. Send FACE SHEET, INSURANCE CARD and most recent provider chart or progress note.

LABS TO BE DRAWN (orders must be placed in Legacy or TVC EPIC by ordering provider if Legacy or TVC provider):

☐ Basic Metabolic Set, Routine, every _____(visit)(days)(weeks)(months) - Circle one
☐ Comprehensive Metabolic Set, Routine, every _____(visit)(days)(weeks)(months) - Circle one
☐ CBC with differential, Routine, every _____(visit)(days)(weeks)(months) - Circle one
☐ Other: ___________________________________________________________________

LINE CARE ORDERS:

☐ Nursing communication order, every visit: Manage line per LH policy 904.4007 IV Catheter Insertion (Peripheral) and LH 904.4004 IV Access: Central Catheters.

PRE-MEDICATIONS:

☐ ____________________________________________________________________________

☐ ____________________________________________________________________________

☐ ____________________________________________________________________________

MEDICATIONS:

☐ ____________________________________________________________________________

☐ ____________________________________________________________________________

☐ ____________________________________________________________________________

Last updated 04/22/2020
# Provider’s Orders

**Patient Name:**

**Date of Birth:**

**Med. Rec. No (TVC MRN Only):**

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## PRN-MEDICATIONS:

- [ ] ________________________________________________________________
- [ ] ________________________________________________________________
- [ ] ________________________________________________________________

## IV FLUIDS:

- [ ] NaCl 0.9% _______ mL IV over ______ minutes
- [ ] Other: ____________________________________________________________

## Frequency of visits: __________________________________________________

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

- [ ] Legacy Day Treatment Unit  
  700 NE 87th Avenue, Suite 360  
  Vancouver, WA 98664  
  Phone number: 360-896-7070  
  Fax number: 360-487-5773

- [ ] Legacy Salmon Creek Day Treatment Unit  
  2121 NE 139th Street, Suite 110  
  Vancouver, WA 98686  
  Phone number: 360-487-1750  
  Fax number: 360-487-5773

- [ ] Legacy Silverton STEPS Clinic  
  Legacy Silverton Medical Center  
  342 Fairview Street  
  Silverton, OR 97381  
  Phone number: 503-873-1670  
  Fax number: 503-874-2483

- [ ] Legacy Emanuel Day Treatment Unit  
  501 N Graham Street, Suite 540  
  Portland, OR 97227  
  Phone number: 503-413-4608  
  Fax number: 503-413-4887

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**Provider signature:** _________________________________  **Date/Time:** _________________________________

**Printed Name:** _________________________________  **Phone:** _______________  **Fax:** _______________

**Organization/Department:** _________________________________

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Last updated 04/22/2020