Outpatient Port Care Order Set

Klickitat Valley Health
Phone: 509-772-2695 Fax: 509-773-3354

General

Patient Name _____ DOB _____ Height _____ Weight _____ Phone #_____

Order Start Date _____ Order Expiration Date *(max one year)* _____

Allergies: _____

Guidelines for Ordering:

1. Send **FACE SHEET** and **H&P** or most recent chart note.
2. Please provide Port Information:
   Port Placement Date: _____
   Type of Port (ex. PowerPort, Port-a-Cath): _____

Port Access

☐ Access implanted port with a ____ gauge ____ inch port access kit per KVH Lippincott procedure "Implanted Port Accessing", ONCE, every _____ (days)(weeks)(months) – *Circle One*

Labs (*please specify frequency and labs to be drawn*)

☐ May obtain labs from port prior to deaccess:

_____

_____

_____

_____

Port Deaccess

☐ Flush port with 20mL sodium chloride 0.9%, then Heparin lock with 500unit/5mL heparin flush, Deaccess port, and apply sterile gauze dressing to site.

Patient Name:
DOB:

Ordering Facility/Provider Information

By signing below, I affirm the following:

I am responsible for the care of the patent identified on this form.

I hold an active, unrestricted license to practice medicine in _____ *(specify state)*

My physician license number is # _____ 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 _____**

Printed name: _____ **Phone: _____** **Fax: _____**

KVH Provider Co-signature:

**Required for all external orders*

Provider Signature: _____ **Date _____**

Printed name: _____

Patient Name:
DOB: