LEGACY HEALTH	**Legacy Day Treatment Unit Provider's Orders** Adult Ambulatory Infusion Order Albumin Orders	**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.**

Albumin 25%

- ☐ 25 grams IV post paracentesis, ONCE
- ☐ 50 grams IV post paracentesis, ONCE
- ☐ __ grams IV post paracentesis, if less than 5 liters removed, ONCE
- ☐ __ grams IV post paracentesis, if greater than or equal to 5 liters removed, ONCE

ANTI-EMETICS:

- ☐ Ondansetron (Zofran) _____ mg PO / IV, ONCE, PRN nausea
- ☐ Dexamethasone (Decadron) _____ mg PO / IV, ONCE, PRN nausea
- ☐ Lorazepam (Ativan) _____ mg PO / IV, ONCE, PRN nausea or anxiety
- ☐ Other _____

OTHER MEDICATIONS (Please include dose, route, frequency and indication):

_____

_____

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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

Provider Signature: _____ **Date:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____

Contact name/number for questions: _____