



134 Prince Avenue, Suite B
 Bellingham, WA 98226
 Phone (360) 933-4892
 Fax (360) 933-1197

Patient Name: _____

Date of Birth: _____ Weight: _____

IV Access: _____ Height: _____

Allergies: _____

Iron Order Form

◆ **Orders are initiated unless crossed out by provider.**

Box must be checked to initiate order.

Please complete this form and fax to (360)933-1197. Call our office and our clinical pharmacists will be happy to make therapy recommendations.

Diagnoses:

- | | |
|--|---------------|
| <input type="checkbox"/> Iron Deficiency Anemia secondary to blood loss | ICD-10: D50.0 |
| <input type="checkbox"/> Iron Deficiency Anemia secondary to inadequate dietary intake | ICD-10: D50.8 |
| <input type="checkbox"/> Unspecified Iron Deficiency Anemia | ICD-10: D50.9 |
| <input type="checkbox"/> Other: _____ | ICD-10: _____ |

Medication Orders:

Iron Sucrose (Venofer): _____ mg IV every _____ days for _____ doses.
 (Optimal frequency is ≤ 3 times weekly)

Ferric Carboxymaltose (Injectafer): 15 mg/kg (max 750 mg) IV every 7 days for 2 doses

Alternate instructions: _____

Other formulation: _____

- ◆ Alteplase 2mg IV to de clot central IV access per Infusion Solutions protocol as needed for occlusion.
- ◆ Flush line with 0.9% NaCl and/or Heparin 10 units/ml or 100 units/ml per Infusion Solutions protocol.
- ◆ Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).
- ◆ Infusion Reaction Management per Infusion Solutions Protocol as needed.

Nursing Orders:

- ◆ Obtain vital signs before start of therapy.
- ◆ Observe for hypotension and have Infusion Reaction Management kit with 0.9% Sodium Chloride immediately available.
- ◆ RN to insert Peripheral IV, rotate sites as needed, and remove after completion of therapy.
- Other: _____

Labs:

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> CBC w/ diff | <input type="checkbox"/> 1 week after therapy completion | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> Serum ferritin | <input type="checkbox"/> 1 week after therapy completion | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> TIBC (includes iron & transferritin sat.) | <input type="checkbox"/> 1 week after therapy completion | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> Other: _____ | every _____ | |

 Prescriber Signature

 Date

 Please Print Name