Infusion Solutions Inc.
Home Infusion & Specialty Pharmacy
477 W. Horton Rd.
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:

- ❑ Iron Deficiency Anemia secondary to blood loss — ICD-10: D50.0
- ❑ Iron Deficiency Anemia secondary to inadequate dietary intake — ICD-10: D50.8
- ❑ Unspecified Iron Deficiency Anemia — ICD-10: D50.9
- ❑ Other: _____ ICD-10: _____

Screening: Does patient have a history of: ❑drug allergies ❑asthma ❑autoimmune disorder_____

Is the patient pregnant? ❑Yes ❑No

Medication Orders:

- ❑ Iron Sucrose (Venofer): _____ mg IV every _____ days for _____ doses.

  (Recommend 100-400 mg per dose; 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 declot 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 NS immediately available.
- RN to insert Peripheral IV, rotate sites as needed, and remove after completion of therapy.
- ❑ Other: _____

Labs:

- ❑ CBC w/ diff — ❑ 1 week after therapy completion — ❑ every _____
- ❑ Serum ferritin — ❑ 1 week after therapy completion — ❑ every _____
- ❑ TIBC (includes iron & transferritin sat.) — ❑ 1 week after therapy completion — ❑ every _____
- ❑ Other: _____ every _____

_____ _____

Prescriber Signature *Date*

_____

Please Print Name

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