ADULT AMBULATORY INFUSION ORDER
Iron Dextran (INFED) Infusion

Weight: ____________ kg  Height: ____________ cm

Allergies: __________________________________________

Diagnosis Code: _____________________________________

Treatment Start Date: ____________  Patient to follow up with provider on date: ____________

**This plan will expire after 365 days at which time a new order will need to be placed**

GUIDELINES FOR ORDERING
1. Ferritin must be obtained within 90 days prior to start of treatment. Labs drawn date: ____________
2. Oral iron should be discontinued prior to administration of iron dextran.
3. Premedication is not required prior to infusion of iron dextran. If premedication is needed, such as in patients with multiple drug allergies, history of asthma, or history of reaction to iron products; consider premedication with hydrocortisone. For treatment of mild infusion reactions, consider treatment with hydrocortisone. Avoid use of diphenhydramine to be used as a premedication or treatment of mild reactions.

LABS:
1. NURSING COMMUNICATION – Remind patient to contact provider to set up lab draw, approximately 4 weeks after treatment infusion

NURSING ORDERS:
1. Please ensure patient has been scheduled for follow-up labs and visit with the provider.
2. TREATMENT PARAMETERS – Ferritin must be obtained within 90 days prior to start of treatment. Hold iron dextran and notify provider if Ferritin greater than 300.
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

MEDICATIONS:

☐ iron dextran (INFED) ____________ mg in NaCl 0.9% 500 mL, intravenous, ONCE
   Maximum 3000 mg per single infusion

   Doses up to 1000 mg infuse over 1 hour, 1001-2000 mg over 3 hours, and greater than 2000 mg over 4-6 hours. Flush vein with NaCl 0.9% when infusion is complete.

Interval: (must check one)

☐ ONCE
☐ Once a week x _____ doses
☐ Twice a week x _____ doses
☐ Three times per week x _____ doses
☐ Every other week x _______ doses
☐ Specific days x _____ doses. List dates: ____________________________________________
AS NEEDED MEDICATIONS:
1. sodium chloride 0.9%, 500 mL, intravenous, AS NEEDED x1 dose for vein discomfort. Give concurrently with iron

HYPERSENSITIVITY MEDICATIONS:
1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (Policy HC-PAT-133-GUD). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction, Dilute vial by either pressing chamber for Act-O-Vial or diluting powder vial with 2 mL SWFI or NS for injection.
5. famotidine (PEPCID) IV, 20 mg, intravenous, AS NEEDED x1 dose, for hypersensitivity reaction
By signing below, I represent the following:
I am responsible for the care of the patient (who is identified at the top of this form);
I hold an active, unrestricted license to practice medicine in: □ Oregon □ ________________ (check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon);

My physician license Number is # ________________ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); 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/Time: ______________________________
Printed Name: ______________________________ Phone: ______________ Fax: ______________

OLC Central Intake Nurse:
Phone: 971-262-9645 (providers only) Fax: 503-346-8058

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

- **Beaverton**
  - OHSU Knight Cancer Institute
  - 15700 SW Greystone Court
  - Beaverton, OR 97006
  - Phone number: 971-262-9000
  - Fax number: 503-346-8058

- **NW Portland**
  - Legacy Good Samaritan campus
  - Medical Office Building 3, Suite 150
  - 1130 NW 22nd Ave.
  - Portland, OR 97210
  - Phone number: 971-262-9600
  - Fax number: 503-346-8058

- **Gresham**
  - Legacy Mount Hood campus
  - Medical Office Building 3, Suite 140
  - 24988 SE Stark
  - Gresham, OR 97030
  - Phone number: 971-262-9500
  - Fax number: 503-346-8058

- **Tualatin**
  - Legacy Meridian Park campus
  - Medical Office Building 2, Suite 140
  - 19260 SW 65th Ave.
  - Tualatin, OR 97062
  - Phone number: 971-262-9700
  - Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders