



Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071



ADULT AMBULATORY INFUSION ORDER
Iron Dextran (INFED) Infusion

Page 1 of 3

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

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: _____



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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 x 1 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



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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