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

ADULT AMBULATORY INFUSION ORDER
Iron Dextran (INFED) Infusion

Account NO.  
MED. REC. NO.
NAME  
BIRTHDATE

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. Provider must order and obtain a ferritin prior to patient being scheduled for iron infusion. 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. TREATMENT PARAMETERS – Hold treatment and notify provider if Ferritin greater than 300 ng/mL.
2. Please ensure patient has been scheduled for follow-up labs and visit with the provider.
3. Life-threatening anaphylactic reactions have occurred. Patient should be observed for anaphylactic reaction during any iron dextran administration.
4. 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
☐ Other: ____________________________

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, HMC C-132). 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