**ADULT AMBULATORY INFUSION ORDER**

**Sodium Ferric Gluconate Complex (FERRLECIT) Infusion**

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**Patient Identification**

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**GUIDELINES FOR ORDERING**

1. Send FACE SHEET and H&P or most recent chart note.
2. Provider must order and obtain a ferritin prior to patient being scheduled for iron infusion. Labs drawn date: _____________

**NURSING ORDERS:**

1. TREATMENT PARAMETERS – Hold treatment and notify provider if Ferritin greater than 300 ng/mL.
2. Ensure patient has been scheduled for follow-up labs and visit with the provider.
3. Monitor patient for signs and symptoms of hypotension during and following administration.
4. Monitor patient for signs and symptoms of hypersensitivity during the infusion and for at least 30 minutes after completion of the infusion.
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

**MEDICATIONS:**

sodium ferric gluconate complex (FERRLECIT) 125 mg in sodium chloride 0.9% 100 mL, intravenous, over 1 hour

**Interval:**

- [ ] Once
- [ ] Other: ______________________

**AS NEEDED MEDICATIONS:**

1. sodium chloride 0.9% bolus, intravenous, 500 mL, AS NEEDED x1 dose, for vein discomfort tolerability. Give concurrently with ferric gluconate
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 (OHSU 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 x 1 dose for hypersensitivity or infusion reaction
3. Epinephrine HCl (Adrenaline) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. Hydrocortisone sodium succinate (Solu-Cortef) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. Famotidine (Peptic) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion 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: __________
Central Intake:
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