
 <p><b>Oregon Health &amp; Science University Hospital and Clinics Provider's Orders</b></p> <p>PO7071</p>  <p>ADULT AMBULATORY INFUSION ORDER <b>Iron Dextran (INFED) Infusion</b></p> <p>Page 1 of 3</p>	<p>ACCOUNT NO. MED. REC. NO. NAME BIRTHDATE</p> <p style="text-align: right;"><i>Patient Identification</i></p>
<p align="center"><b>ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK ( ✓ ) TO BE ACTIVE.</b></p>	

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) 1000 mg in sodium chloride 0.9% 500 mL, intravenous, ONCE, over 1 hour.

**AS NEEDED MEDICATIONS:**

1. sodium chloride 0.9%, 500 mL, intravenous, AS NEEDED x1 dose for vein discomfort. Give concurrently with iron



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**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 (ADRENALIN) 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 (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion 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:** \_\_\_\_\_

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](http://www.ohsuknight.com/infusionorders)