
 <div style="text-align: center;"> Oregon Health & Science University Hospital and Clinics Provider's Orders </div> <div style="text-align: center; margin-top: 10px;">  </div> <div style="text-align: center; margin-top: 10px;"> <small>ADULT AMBULATORY INFUSION ORDER</small> Iron Dextran (INFED) Infusion </div> <div style="text-align: center; margin-top: 10px;"> <small>Page 1 of 3</small> </div>	<div style="margin-top: 10px;"> <small>ACCOUNT NO.</small> <small>MED. REC. NO.</small> <small>NAME</small> <small>BIRTHDATE</small> </div> <div style="text-align: right; margin-top: 20px; font-size: small;"> <i>Patient Identification</i> </div>
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. Send **FACE SHEET and H&P or most recent chart note.**
2. If patient is pregnant, estimated due date is: _____.
3. Provider must order and obtain a ferritin prior to patient being scheduled for iron infusion.
 Labs drawn date: _____"
 Copy of ferritin must be attached.
4. Many insurance providers require a ferritin result within 90 days. If ferritin is not within 90 days of signed date then patient's insurance may deny coverage for this treatment.
5. Oral iron should be discontinued prior to administration of iron dextran.
6. 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.

NURSING ORDERS:

1. TREATMENT PARAMETERS – Hold treatment and notify provider if Ferritin greater than 300 ng/mL.
2. Instruct patient to set follow up appointment with provider for follow up labs.
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, declothing (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



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

ADULT AMBULATORY INFUSION ORDER
Iron Dextran (INFED) Infusion

Page 2 of 3

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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

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. NURSING COMMUNICATION – Avoid intravenous or oral diphenhydramine, move to next option in the algorithm. Adverse effects of diphenhydramine may overlap with IV iron adverse effects such as flushing, hypotension, tachycardia.
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

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:** _____



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

ADULT AMBULATORY INFUSION ORDER
Iron Dextran (INFED) Infusion

Page 3 of 3

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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

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