



134 Prince Avenue, Suite B  
 Bellingham, WA 98226  
 Phone (360) 933-4892  
 Fax (360) 933-1197

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Weight (kg): \_\_\_\_\_

IV Access: \_\_\_\_\_

Allergies: \_\_\_\_\_

### Iron Order Form

◆ **Orders are initiated unless crossed out by provider.**

**Check box to initiate order.**

Please complete this form and fax to (360)933-1197. Call our office and our clinical pharmacists will be happy to make therapy recommendations.

**Diagnoses:**

- |  |              |
|--|--------------|
| <input type="checkbox"/> Iron Deficiency Anemia secondary to blood loss                | ICD-9: 280.0 |
| <input type="checkbox"/> Iron Deficiency Anemia secondary to inadequate dietary intake | ICD-9: 280.1 |
| <input type="checkbox"/> Unspecified Iron Deficiency Anemia                            | ICD-9: 280.9 |
| <input type="checkbox"/> Other: _____  | ICD-9: _____ |

**Medication Orders:**

Iron Sucrose (Venofer): \_\_\_\_\_ mg every \_\_\_\_\_ days for \_\_\_\_\_ doses.

\*\*Optimal frequency is ≤ 3 times weekly

Other: \_\_\_\_\_

- ◆ Alteplase 2mg IV to de clot central IV access per Infusion Solutions protocol as needed for occlusion.
- ◆ Flush line with 0.9% NaCl and/or Heparin 10 units/ml or 100 units/ml per Infusion Solutions protocol.
- ◆ Infusion Reaction Management per Infusion Solutions Protocol as needed.

**Nursing Orders:**

- ◆ Obtain vital signs before start of therapy.
- ◆ Observe for hypotension and have Anaphylaxis kit with 0.9% Sodium Chloride immediately available.
- RN to insert peripheral IV, rotate sites every 72 to 120 hours, and remove after completion of therapy.
- Other: \_\_\_\_\_

**Labs:**

- |  |                                 |                                      |
|--|---------------------------------|--------------------------------------|
| <input type="checkbox"/> CBC                                 | <input type="checkbox"/> weekly | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> Serum ferritin                      | <input type="checkbox"/> weekly | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> Hemoglobin                          | <input type="checkbox"/> weekly | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> Hematocrit                          | <input type="checkbox"/> weekly | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> Transferrin Saturation              | <input type="checkbox"/> weekly | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> Serum Iron (≥48 hours after dosing) | <input type="checkbox"/> weekly | <input type="checkbox"/> every _____ |
| <input type="checkbox"/> Other: _____ every _____            |                                 |                                      |

\_\_\_\_\_  
*Prescriber Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Please Print Name*