



477 W. Horton Rd.
 Bellingham, WA 98226
 Phone (360) 933-4892
 Fax (360) 933-1197

Patient Name: _____

Date of Birth: _____ Weight: _____

IV Access: _____ Height _____

Allergies: _____

Iron Order Form

Please fax this form, copies of insurance cards, demographics, and supporting clinical documentation to
(360) 933-1197 to facilitate an efficient referral. Thank you for choosing Infusion Solutions!

- Diagnoses:**
- | | |
|--|---------------|
| <input type="checkbox"/> Iron Deficiency Anemia secondary to blood loss | ICD-10: D50.0 |
| <input type="checkbox"/> Iron Deficiency Anemia secondary to inadequate dietary intake | ICD-10: D50.8 |
| <input type="checkbox"/> Unspecified Iron Deficiency Anemia | ICD-10: D50.9 |
| <input type="checkbox"/> Other: _____ | ICD-10: _____ |

Screening: Does patient have a history of: drug allergies asthma autoimmune disorder _____
 Is the patient pregnant? Yes No

Medication Orders:

- Iron Sucrose (Venofer): _____ mg IV every 3-7 days for _____ doses. Alternate frequency? _____
 (Recommend 100-300 mg per dose, and 1,000 mg per course; optimal frequency is ≤ 3 times weekly)
- Ferric Derisomaltose (MonoFerric): 20 mg/kg (max 1,000 mg) IV for 1 dose. Monitor for 30 minutes.
 Alternate instructions: _____
- Ferric Carboxymaltose (Injectafer): 15 mg/kg (max 750 mg) IV every 7 days for 2 doses.
 Alternate instructions: _____
- Other formulation/instructions: _____
- ◆ Alteplase 2mg IV to declot 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.
- ◆ Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).
- ◆ Infusion Reaction Management per Infusion Solutions Protocol as needed.

Nursing Orders:

- ◆ Obtain vital signs before start of therapy.
- ◆ Observe for hypotension and have Infusion Reaction Management kit with NS immediately available.
- ◆ RN to insert Peripheral IV, rotate sites as needed, and remove after completion of therapy.
- Other: _____

Labs:

- Prescriber to order follow up labs as needed after Infusion Solutions therapy completed.
 (Recommend CBC w/ diff, Serum ferritin, TIBC at least 2 weeks post treatment)
- For patients on chronic iron therapy, Infusion Solutions to draw labs:
 Order: _____

 Prescriber Signature

 Date

 Please Print Name

KEY: ◆ Orders are initiated unless crossed out by provider.
 Box must be checked to initiate order.