Ascension St. Vincent's
Southside Infusion Center
Phone: 904-296-5994 Fax: 904-296-9070

Patient Name:_____
Date of Birth:_____
Patient Phone #:_____
Insurance:_____
Subscriber ID:_____

IV Iron (Ferrlecit, Injectafer, Venofer, Infed) Order Set

Fill out all information on this form and attach the following as appropriate:
-Copy of prescription/medical card (front and back) -Pertinent labs related to diagnosis and medication administration -Pertinent clinical/ progress notes and tests supporting diagnosis.
-Sign, date and fax to: 904-296-9070

General Information

Height	_____ inches	**Weight**	_____ kg	**Allergies**	☐ NKDA	☐ List: _____

Diagnosis	**ICD 10 Code(s)**	**J Code**	**CPT Code**
☐ 1st Trimester Anemia Complicating Pregnancy ☐ 2nd Trimester Anemia Complicating Pregnancy ☐ 3rd Trimester Anemia Complicating Pregnancy ☐ Iron Deficiency Anemia (non-pregnant) ☐ Other: _____	☐ O99.011 ☐ O99.012 ☐ O99.013 ☐ D50.9 ☐ Other: _____	☐ Sodium Ferric Gluconate: J2916 ☐ Ferric Carboxymaltose: J1439 ☐ Iron Sucrose: J1756 ☐ Iron Dextran: J1750	☑ CPT Code: _____

Nursing Orders	**Pre-medications (not required)**	
☑ Discharge patient when stable and meets protocol criteria	☐ Acetaminophen 975 mg PO, once	☐ Diphenhydramine 25 mg PO, once
Emergency/Anaphylaxis Order	☐ Cetirizine 10 mg PO, once	☐ Diphenhydramine 25 mg IV, once
☑ Follow standard orders for management of allergies and anaphylaxis reactions	☐ Dexamethasone 20 mg IV, once	☐ Other: _____
	☐ Ondansetron 4 mg IV, once	☐ Other: _____

Diet (prior to scheduling infusion)	☑ Regular Diet

Medication Orders

	Medication	**Route**	**Dose**	**Frequency**	**Infuse Over**	**Treatment Type (Select one)**
☐	Ferric Gluconate (Ferrlecit)	IV	☐ 125 mg ☐ 250 mg	Once	☐ 60 minutes ☐ 120 minutes	☐ One time order only ☐ Every ____ day(s) for ____ dose(s) ☐ Every ____ week(s) for ____ dose(s) ☐ Every ____ month(s) for ____ dose(s)
☐	Ferric Carboxymaltose (Injectafer)		☐ 750 mg ☐ 1000 mg		☐ IV slow push (doses </=750mg) ☐ 15 minutes	
☐	Iron Sucrose (Venofer)		☐ 100 mg ☐ 200 mg ☐ 300 mg		☐ Slow push over 2-5 minutes ☐ 15 minutes (</=200mg) ☐ 1.5 hours (300 mg)	
☐	LMW Iron Dextran (Infed)		☐ 1000 mg: 25 mg test dose, then 975 mg		☐ Give test dose over 30 min, check VS and observe for 15 minutes then infuse full dose over 1 hour	
☐	Blood Transfusion (PRBC)		☐ 2 units		☐ ____ minutes	

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Order Comments: *Test dose for Infed is required prior to full infusion dose. Administer test dose prior to full dose. Check vital signs and observe for 15 minutes after the test dose is given prior to administering the full dose.

Infusion Center Staff Please fax infusion records or discharge summary to:	**Fax Number** _____

Provider Signature		**Date**	
Provider Printed Name			