PROVIDENCE Health & Services

ADULT AMBULATORY INFUSION ORDER
POIRONSUC-06/21
IRON SUCROSE (VENOFER) Infusion

NAME:
BIRTHDATE:
INSURANCE:
PROVIDER NAME:
CLINIC NAME and Phone number:

Patient identification

Weight: _____ kg **H**eight: _____cm **A**llergies: _____ **D**iagnosis Code: _____
Treatment Start Date: _____

****These orders will expire after 365 days; new orders are needed after the expiration date****

GUIDELINES FOR ORDERING

1. Send FACE SHEET and H&P or most recent chart note.

MEDICATIONS: (must check one)

Iron sucrose (VENOFER): *(must check one)*

- ☐ 100 mg in sodium chloride 0.9% 100 mL, intravenous, ONCE, over 30 minutes
- ☐ 200 mg in sodium chloride 0.9% 100 mL, intravenous, ONCE, over 30 minutes
- ☐ 300 mg in sodium chloride 0.9% 250 mL, intravenous, ONCE, over 1.5 hours
- ☐ 400 mg in sodium chloride 0.9% 250 mL, intravenous, ONCE, over 2.5 hours
- ☐ 500 mg in sodium chloride 0.9% 250 mL, intravenous, ONCE, over 3.5 hours

Interval: *(must check one)*

- ☐ Once.
- ☐ Daily x _____ doses.
- ☐ Every other day x _____ doses.
- ☐ Every _____weeks x _____ doses.
- ☐ Monthly x _____ doses
- ☐ Other: _____.

AS NEEDED MEDICATIONS:

- ☐ Sodium chloride 0.9%, 500 mL, intravenous, AS NEEDED x1 dose for vein discomfort. Give concurrently with iron.

Standard included Nursing Orders:

- ✓ Vital signs: Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion and at the end of infusion.
- ✓ If hypersensitivity or infusion reactions develop, temporarily hold the infusion, and notify provider immediately.
- ✓ Include hypersensitivity reaction order set. (See attached form).

PROVIDENCE Health & Services **ADULT AMBULATORY INFUSION ORDER** **POIRONSUC-06/21** **IRON SUCROSE (VENOFER) Infusion**	**NAME:** **BIRTHDATE:** **INSURANCE:** **PROVIDER NAME:** **CLINIC NAME and Phone number:** **Patient identification**

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.

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 medications and blood products described above for the patient identified on this form.

Provider's printed name: _____
Provider's signature: _____
Date: _____

Outpatient Infusion Services Intake Team:
Please check the appropriate box for the patient's preferred infusion center location:

Outpatient Infusion Services

☐	**PORTLAND**	**Phone 503-215-6046**	**Fax 503-487-3582**
☐	**WILLAMETTE FALLS**	**Phone 503-215-6046**	**Fax 503-487-3582**
☐	**MEDFORD**	**Phone 541-732-7048**	**Fax 541-732-3939**
☐	**HOOD RIVER**	**Phone 541-387-1338**	**Fax 541-387-6137**
☐	**SEASIDE**	**Phone 503-717-7671**	**Call for fax #**
☐	**NEWBERG**	**Phone 503-537-1450**	**Fax 503-537-1449**

Reviewed 8/27/21 R Grabowski