

INFUSION SUITE		IRON INFUSION ORDERS		
Durango Infusion Center 270 E 8th Ave Ste N101 Durango, CO 81301		Phone: 970-828-3500 Fax: 970-828-3501		
PATIENT INFORMATION - If Outside Referral, Include Patient Demographics and Insurance Cards				
Name:		DOB:		
MEDICAL INFORMATION				
ICD10 / Diagnosis:		Height:		
Allergies / Hypersensitivities:		Weight (kg):		
		*Weigh patient at each visit		
REQUIRED CLINICAL DOCUMENTATION				
<input type="checkbox"/> CBC		<input type="checkbox"/> Iron Studies		
Additional labs:				
<input type="checkbox"/> Insert IV		<input type="checkbox"/> Access Port/PICC		
PREMEDICATIONS 30 minutes prior to starting				
<input type="checkbox"/> Acetaminophen:	<input type="checkbox"/> 325mg PO X1	<input type="checkbox"/> 500mg PO X1	<input type="checkbox"/> 650mg PO X1	<input type="checkbox"/> 1000mg PO X1
<input type="checkbox"/> Diphenhydramine:	<input type="checkbox"/> 25mg IV X1	<input type="checkbox"/> 25mg PO X1	<input type="checkbox"/> 50mg IV X1	<input type="checkbox"/> 50mg PO X1
<input type="checkbox"/> Methylprednisolone:	<input type="checkbox"/> 40mg IV X1	<input type="checkbox"/> 100mg IV X1	<input type="checkbox"/> 125mg IV X1	
<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Cetirizine 10mg PO X1		<input type="checkbox"/> Loratadine 10mg PO X1	
<input type="checkbox"/> Additional PRN:				
IRON ORDERS				
<input type="checkbox"/> Injectafer 750mg IV _____ mL over 15 minutes X _____ dose		<i>*Max doses =2 and doses should be 7 days apart</i>		
<input type="checkbox"/> Feraheme 510mg IV in _____ mL over _____ minutes X 2 doses		<i>*2nd dose should be given 3-8 days after 1st dose</i>		
<input type="checkbox"/> Monoferric 1000mg IV in _____ mL over 20 minutes X 1 dose (*Over 50kg)				
<input type="checkbox"/> Monoferric 20mg/kg IV in _____ mL over 20 minutes X 1 dose (*Under 50kg)				
<input type="checkbox"/> Venofer 200mg IV in _____ mL NS over _____ 15 minutes X _____ dose				
POST INFUSION				
<input type="checkbox"/> Flush IV line with 25mL NS at the same rate of infusion. D/C IV.				
<input type="checkbox"/> Flush IV line with 25 mL NS. Flush port with 10mL NS, Lock port with 5mL Heparin 10-100U/mL and deaccess				
<input type="checkbox"/> Discharge home following 30 minute observation				
<input type="checkbox"/> Discharge home without observation				
Signature:		Date:		
Provider Name/Credentials:		NPI:		
Provider Name/Credentials:		Provider Name/Credentials:		
Provider Name/Credentials:		Provider Name/Credentials:		
Provider Name/Credentials:		Provider Name/Credentials:		

Nursing Considerations: *No benadryl for infusion related reactions

Monitor for any blood pressure changes.