

[Place patient sticker here]

Name: _____
MRN: _____
DOB: _____

Today's Date _____ Time _____

Diagnosis: _____ Other: _____

Age: _____ Height (cm): _____ Weight (kg): _____ BSA (m²): _____

ALLERGIES/Sensitivities: NKDA or _____

Start Date (at least 1 wk from today): _____ **Urgent (Call Infusion Center)**

Treatment Department: EHW OP Infusion

Appointment Requests: Tolerance: Use default, for chronic treatments order valid for 1 year
 Appointment Request – Infusion – 2 hour Every 7 days x 2 Treatments

Labs: Lab (if selected) will be done as per appointment frequency selected above (unless specified)

- CBC Once on Day 1
- Ferritin Once on Day 1
- Iron and TIBC Once on Day 1

Provider Communication: Order will be done as per appointment frequency
 No routine pre-medications needed

Pre-Medications: Order will be done as per appointment frequency
 Instructions: Give at least 30 minutes prior to infusion

- Acetaminophen tablet 650 mg, oral, Once
- DiphenhydrAMINE 25mg, once (choose one) tablet, Oral injection, IV
- MethylPREDNISolone sodium succinate (PF) injection 40 mg intravenous, once

Supportive Care: Order will be done as per appointment frequency
 sodium chloride prime bag 250 mL
250 mL, intravenous, at 0-999, Once as needed, Prime Bag

All information provided on this form & calculations have been independently confirmed & recalculated as indicated by signature(s) below

Licensed Medical Professional

Attending Physician

Print Name: _____
Signature _____
Date _____
Contact # _____

Print Name: _____
Signature _____
Date _____
Contact # _____

Name: _____
MRN: _____
DOB: _____

Nursing Orders:

Medication Observation/Monitoring Communication

- Observation time in addition to infusion duration (min): 30
- When: Post-dose
- Post-dose tasks: Possible reaction

Medication:

Every 7 days x 2 Treatments

- ferumoxytol (Feraheme®) 510 mg in sodium chloride 0.9 % 117 mL IVPB
- 510 mg, intravenous, Administer over: 15 Minutes, Once

Emergency Medications

Order will be done as per appointment frequency

- Hypersensitivity reaction protocol

Protocol Document: <https://emory.ellucid.com/documents/view/15307/15641>

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Licensed Medical Professional

Print Name: _____
Signature _____
Date _____
Contact # _____

Attending Physician

Print Name: _____
Signature _____
Date _____
Contact # _____