

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 – 3 hours Once

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

- | | |
|--|-------------------------------|
| <input type="checkbox"/> CBC & Diff | <input type="checkbox"/> Once |
| <input type="checkbox"/> Ferritin | <input type="checkbox"/> Once |
| <input type="checkbox"/> Iron and TIBC | <input type="checkbox"/> Once |
| <input type="checkbox"/> Reticulocytes | <input type="checkbox"/> Once |

Pre-Medications: all optional Frequency: Once

- Prochlorperazine, tablet 10 mg, oral, Once
- methylPREDNISolone sod sue (PF), injection 125 mg, intravenous, Once
- diphenhydramine, oral 50 mg, oral, Once

Supportive Care:

- sodium chloride prime bag 250 ml
250 ml, intravenous, at 0-999, Once as needed, Prime Bag

Observation Orders: Order frequency as per appointment request

- Observe/Monitor patient for signs/symptoms of hypersensitivity reactions during infusion and for 30 minutes following each infusion

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

Licensed Medical Professional

Print Name: _____
Signature _____
Date _____
Contact # _____

Attending Physician

Print Name: _____
Signature _____
Date _____
Contact # _____

Name: _____
MRN: _____
DOB: _____

Medication: Choose ONE dosing option below

Iron Dextran - Test Dose (1000mg total)

- iron dextran (Infed®) 25 mg in 10 ml NS
25 mg, intravenous, Once
Administer over: 2 Minutes
 - Following administration of test dose, observe patient per default parameters
 - If no reaction, proceed with full dose below.
- iron dextran (Infed®) IV 975 mg
975 mg, intravenous, Administer over: 1 Hours, Once
Administer after test dose if patient tolerates test dose

Iron Dextran - No Test Dose (1000mg total)

- iron dextran (Infed®) IV 1,000 mg
1,000 mg, intravenous, once. Administer over: 1 Hour
- Provider Communication: No Iron Dextran Test Dose Required

Iron Dextran - Test Dose (2000 mg total)

- iron dextran (Infed®) 25 mg in 10 ml NS
25 mg, intravenous, once. Administer over: 2 Minutes
 - Following administration of test dose, observe patient per default parameters
 - If no reaction, proceed with full dose below.
- iron dextran (Infed®) IV 1,975 mg
1,975 mg, intravenous, once. Administer over: 2 Hours
Administer after test dose if patient tolerates test dose

Iron Dextran - No Test Dose (2000 mg total)

- iron dextran (Infed®) IV 2,000 mg
2,000 mg, intravenous, once, Administer over: 2 Hours
- Provider Communication: No Iron Dextran Test Dose Required

Iron Dextran Maintenance (choose one)

- iron dextran (Infed®) IV 1,000 mg
1,000 mg, intravenous, once, Administer over: 1 Hours
- iron dextran (Infed®) IV 2,000 mg
2,000 mg, intravenous, once, Administer over: 2 Hours

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: _____
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Date _____
Contact # _____

Attending Physician

Print Name: _____
Signature _____
Date _____
Contact # _____