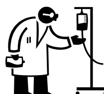

Infusion Associates
3230 Eagle Park NE, Suite 101
Grand Rapids, MI 49525
Phone: 616-954-0600 Fax: 616-954-1675

IV IRON INFUSION ORDERS

******Please fax a copy of patient's Demographics, Insurance information, Current Lab Results, H&P, and Current Medications*

Date: _____/_____/_____

Patient Name: ____ **DOB**: ______/_____/________

Allergies: ______________________________ **Patient Weight:** _________lbs / kg **Height:**________________

Diagnosis:_________________________________ **Hemoglobin and date collected:**________________________

Is patient on hemodialysis: YES NO

DX CODES: ***ICD-10*** : _______________________, ________________________, __________________________

LABS to be drawn 2 weeks post infusion: ☐ **Pharmacist to order labs per protocol**

☐ CBC ☐ Iron Studies (Iron, T-sat, Tibc, Ferritin) ☐ Other: _________________

Pre- Medications: **(NOT INDICATED per P.I.)**

Benadryl PO	25mg or 50mg	☐Yes	☐ No
Tylenol PO	650mg	☐Yes	☐ No

IV Iron: ☐ **Pharmacist to dose** **Start Date of Infusion**: _____/_____/_____

☐ **Venofer IV** (***Iron Sucrose***) **:**

Dose (circle one)**: 100 mg 200 mg 300 mg**
Number of doses: _______________________
Frequency:_______________________________

☐ **Injectafer IV** (***Ferric carboxymaltose***) **:**

Dose: ____750 mg____________
Number of doses (circle one) **: One Two**
Frequency: ____Weekly_______

☐ **Ferrlecit IV** (***Ferric gluconate***)
Dose: ____125 mg____________
Number of doses: ______________
Frequency:_____________________

Expiration Date: _____/_____/_____

Is patient on oral iron? ☐ **YES** ☐ **NO** **If yes, is patient to discontinue?** ☐ **YES** ☐ **NO**

Printed Provider's Name: ____

Provider Signature: ____

Office Phone Number: _______________________ **Fax Number:** ______________________________________