 <p>LEGACY HEALTH</p>	<p><b>Legacy Day Treatment Unit Provider's Orders</b></p> <p>Adult Ambulatory Infusion Order IRON DEXTRAN</p>	<p><b>Patient Name:</b> _____</p> <p><b>Date of Birth:</b> _____</p> <p><b>Med. Rec. No (TVC MRN Only):</b> _____</p>
<p>ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE</p>		

**Anticipated Start Date:** \_\_\_\_\_ **Patient to follow up with provider on date:** \_\_\_\_\_

**\*\*\*This plan will expire after 365 days, unless otherwise specified below\*\*\***

**Orders expire:** \_\_\_\_\_

**Weight:** \_\_\_\_\_ kg    **Height:** \_\_\_\_\_ cm

**Allergies:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**Diagnosis Code:** \_\_\_\_\_ (please include primary and secondary diagnosis codes)

**GUIDELINES FOR PRESCRIBING:**

1. Send **FACE SHEET, INSURANCE CARD and most recent provider chart or progress note.**
2. Labs: For iron deficient anemia, a CBC, TIBC and Ferritin should be obtained within 90 days of the start of treatment. Date labs drawn: \_\_\_\_\_
3. Please place lab orders, or submit results with infusion order

**LABS TO BE DRAWN (orders must be placed in Legacy or TVC EPIC by ordering provider if Legacy or TVC provider):**


- Ferritin, serum, Routine, every \_\_\_\_\_(visit)(days)(weeks)(months) **Circle one**
- CBC with differential, Routine, every \_\_\_\_\_(visit)(days)(weeks)(months) **Circle one**
- Iron and TIBC, serum, Routine, every \_\_\_\_\_(visit)(days)(weeks)(months) **Circle one**
- Other: \_\_\_\_\_

**PRE-MEDICATIONS:** Premedication is not required prior to infusion of iron dextran, but **hydrocortisone is recommended** to minimize any reactions. If hydrocortisone is not desired, please cross out the pre-checked order below and select either no routine pre-medications box or specify the other medication in the designated section below:

- Hydrocortisone 100 mg IV, ONCE x1 dose, 30 minutes prior to infusion, every visit
- Other: \_\_\_\_\_, 30 minutes prior to infusion, every visit
- No routine pre-medications

**LINE CARE ORDERS:**

- Nursing communication order, every visit: Manage line per LH policy 904.4007 IV Catheter Insertion (Peripheral) and LH 904.4004 IV Access: Central Catheters.

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**MEDICATIONS: (must check one)**

Typical dosing range: 500 – 2000 mg. Standard administration time over 1 – 4 hours with **max 3000 mg per single infusion.**

- iron dextran (Infed) 1000 mg IV infusion in 500 mL NS over 1 hours
- iron dextran (Infed) 2000 mg IV infusion in 500 mL NS over 3 hours
- iron dextran (Infed) 3000 mg IV infusion in 500 mL NS over 4 to 6 hours
- iron dextran (Infed) \_\_\_\_\_ mg IV infusion in 500 mL NS over \_\_\_\_ hours

Flush vein with sodium chloride 0.9% IV flush when infusion complete

**Interval: (must check one)**


- Once
- Other: \_\_\_\_\_

**AS NEEDED MEDICATIONS:**

- acetaminophen 650 mg oral, EVERY 4 HOURS AS NEEDED for fever, headache or pain
- diphenhydramine 25 mg oral, EVERY 4 HOURS AS NEEDED for itching
- sodium chloride 0.9% 500 mL IV, AS NEEDED x 1 dose for iron infusion tolerability. Give concurrently with iron dextran

**NURSING ORDERS (TREATMENT PARAMETERS):**

1. Treatment parameters, every visit: Hold iron sucrose and notify provider if ferritin greater than 300
2. Remind patient to contact provider to set up lab draw, approximately 4 weeks after completion of treatment
3. Nursing communication order, every visit: Manage line per LH policy 904.4007 IV Catheter Insertion (Peripheral) and LH 904.4004 IV Access: Central Catheters
4. Nursing communication order, every visit: Monitor patient for potential adverse effects (ADEs) during and after infusion: ADEs may include hypersensitivity reactions (dyspnea, itching, hives, tracheal swelling or swelling of lips, eyelids, tongue and nasal mucosa), local injection site reactions (phlebitis, irritation, discoloration). Delayed reactions may occur within 24-48 hours after administration and include arthralgia, myalgia, backache, chills, dizziness, headache, malaise, nausea, vomiting and fever. Delayed reactions usually subside within 3-4 days.
5. Nursing communication orders, every visit: Manage hypersensitivity reactions per LH 906.6606.
6. Nursing communication orders, every visit: Monitor vital signs every 15 minutes for one hour and then hourly during infusion and at completion of the infusion.

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**HYPERSENSITIVITY MEDICATIONS:** Refer to LH policy 906.6606 Initiation of Emergency Measures for Adult Oncology, Radiation Oncology and Infusion Clinic Patients

1. hydrocortisone 100 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
2. diphenhydramine 25-50 mg IV, AS NEEDED x1 for hypersensitivity reaction
3. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. naloxone (Narcan) 0.4 mg IV, AS NEEDED x1 dose for diminished respiratory rate
6. sodium chloride 0.9% 1000 mL IV, AS NEEDED x 1 dose for alteration in hemodynamic status
7. meperidine 12.5-25 mg IV, AS NEEDED x 2 for rigors
8. Nursing communication order, every visit: Please follow treatment algorithm for acute infusion reaction.

Please check the appropriate box for the patient's preferred clinic location:

- |  |  |
|--|--|
| <input type="checkbox"/> <b>Legacy Day Treatment Unit</b><br>700 NE 87 <sup>th</sup> Avenue, Suite 360<br>Vancouver, WA 98664<br>Phone number: 360-896-7070<br>Fax number: 360-487-5773                | <input type="checkbox"/> <b>Legacy Silverton STEPS Clinic</b><br>Legacy Silverton Medical Center<br>342 Fairview Street<br>Silverton, OR 97381<br>Phone number: 503-873-1670<br>Fax number: 503-874-2483 |
| <input type="checkbox"/> <b>Legacy Salmon Creek Day Treatment Unit</b><br>2121 NE 139 <sup>th</sup> Street, Suite 110<br>Vancouver, WA 98686<br>Phone number: 360-487-1750<br>Fax number: 360-487-5773 | <input type="checkbox"/> <b>Legacy Emanuel Day Treatment Unit</b><br>501 N Graham Street, Suite 540<br>Portland, OR 97227<br>Phone number: 503-413-4608<br>Fax number: 503-413-4887                      |

**Provider signature:** \_\_\_\_\_ **Date/Time:** \_\_\_\_\_  
**Printed Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_  
**Organization/Department:** \_\_\_\_\_