**DOCTOR’S ORDER SHEET**

**DEPARTMENT OF INFUSION SERVICES**

**INTRAVENOUS IRON INFUSIONS**

*This order form is not valid for prescribing of controlled substances*

**Instructions:**
1. Completed and signed doctor’s order sheet form
2. Patient demographics including insurance information
3. Once all items are reviewed ChristianaCare Infusion Services will reach out to your patient to schedule

**Phone:** 302-733-1548
**Access coordinator:** 302-733-1553
**Fax:** 302-733-1561

<table>
<thead>
<tr>
<th>Date:</th>
<th>Insurance Authorization/Prior Auth number:</th>
<th>□ New Referral</th>
<th>□ Order Renewal</th>
<th>□ Medication/Order Change</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Patient name:</td>
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<td></td>
<td>DOB: / /</td>
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<td>Allergies:</td>
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<tr>
<td></td>
<td>Weight: [kg or lb (mark one)]: ___ Date: / /</td>
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<td>ICD 10:</td>
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1) **Intravenous iron order: choose one medication**

   **Iron Sucrose** (e.g. Venofer®)
   - □ 200 mg IV once every ____ days x ____ doses
   - □ 200 mg IV once daily for a total of 5 doses over two weeks
   - □ ___ mg IV once every ____ days x ____ doses

   **Ferric Carboxymaltose** (e.g. Injectafer®)
   - □ 750 mg IV once, repeat dose after at least 7 days for a total of 2 doses

   **Ferumoxytol** (e.g. Feraheme®)
   - □ 510 mg IV once, repeat dose after 3-8 days for a total of 2 doses

   **Iron Dextran** (e.g. Infed®)
   - □ 25 mg IV push test dose once. Observe for 1 hour, if no reaction then proceed with full dose
   - *If no test dose required please provide reason: ____________________________

   **Infusion dose:**
   - □ 1000 mg IV once
   - □ Other: ____________________________

2) **Additional orders:**

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

**Signature/Title**

**Contact phone #**

**Print Name or ID#**

**Date** / / **Time**

**MD5521 (49140)(0121)C**

DOCTOR’S ORDERS - Order
Key:

BID - Twice daily
D5W - Dextrose 5% in water solution
D/C - Discontinue
DOB - Date of birth
HOH - Hard of hearing
hr - Hour
ICD - International Classification of Diseases
IM - Intramuscular
IV - Intravenous
kg - Kilogram
L - Left
LD - Loading dose
LR - Lactated ringers
mcg - Microgram
MD - Maintenance dose
mg - Milligram
min - Minute
mL - Milliliter
ng - Nanogram
NPO - Nothing by mouth
NS - 0.9% sodium chloride
NSS - Normal saline solution
PCA - Patient controlled analgesia
PO - By mouth
PRN - As needed
R - Right
TID - Three times daily
X - Times