IV Iron

6955 Foothill Blvd, Suite 67A, Oakland, CA, 94605
Phone: (510) 878-9528 | Fax: (510) 969-5840 | Email: referrals@totalinfusion.com

Name: ______________________________

DOB: ________________ Phone: ________________

Gender: ☐ Male ☐ Female

Allergies: ______________________________

DIAGNOSIS (ICD-10 code required):

☐ _______ Iron Deficiency

☐ _______ Iron Deficiency Anemia

☐ _______ Other: ____________________

PROVIDER REMINDERS:

- All orders with a ☑ will be placed unless otherwise noted
- Baseline labs: Ferritin, Fasting TSAT, (add H&H if patient is being treated for iron deficiency anemia)

TREATMENT CRITERIA:

Hold IV Iron if:

☐ Ferritin > 200

☐ TSAT > 20%

☐ ______________________________

Nursing Considerations:

- Do not administer repeat doses of Iron Dextran (Infed) without reevaluation of iron labs

Premedications

☐ **No routine premedications necessary.**

☐ **Methylprednisolone Sodium Succinate (SOLU-MEDROL) 125mg IVP,** Once, 30 minutes prior to IV Iron **(NOT ROUTINE; RECOMMENDED FOR PATIENTS WITH A HISTORY OF DRUG ALLERGIES, AN ALLERGIC DIATHESIS OR A HISTORY OF INFLAMMATORY ARTHRITIS, WHEREIN BOTH PARENTERAL AND ORAL IRON HAVE BEEN SHOWN TO EXACERBATE SYMPTOMS)**

☐ ______________________________

☐ ______________________________

☐ **IV LINE CARE** per Nursing Policy

☐ **INFUSION REACTION MEDICATIONS** per Standardized Procedures

Medications

Patient Weight ______kg **(REQUIRED)**

Infusion Therapy (Select One):

☐ **Iron Dextran (INFED),** 1,000mg

- Administer TEST DOSE: 25mg in 50mL 0.9% sodium chloride Intravenously over 5 minutes, then observe 60 minutes
- If no adverse reaction, administer the remaining 975mg in 250mL 0.9% sodium chloride Intravenously over 60 minutes
- If test dose is not required, administer 1,000mg in 250mL 0.9% sodium chloride Intravenously over 60 minutes

A test dose is REQUIRED for the first dose of Iron Dextran (Infed). A repeat test dose will be administered if greater than 6 months since the last Iron Dextran (Infed) infusion.

☐ **Iron Sucrose (VENOFER),** 200mg

- Administer in 100mL 0.9% sodium chloride Intravenously over 15 minutes
- Frequency: every ________ for ________ doses

☐ **Ferric Gluconate (FERRLECIT)** 125mg

- Administer in 100mL 0.9% sodium chloride Intravenously over 60 minutes
- Frequency: every ________ for ________ doses

Special Instruction(s):

Provider Signature ____________________ Date ____________ Email ____________

Printed Name ____________________ Phone ____________ Fax ____________

Office Contact ____________________ Phone ____________ Email ____________