

OP Iron Sucrose (Venofer) IV Daily Referral



Place Patient Label
Inside This Box

***** This section refers to the entire plan. If individual orders need a different interval, please indicate in each section below***** **Version 6/2021**

Date of Infusion: _____	Lead Physician: _____
Patient Name: _____	Date of Birth: _____
Patient SSN (if available): _____	Contact Number: _____
Insurance Name: _____	Policy Number: _____
Secondary Insurance: _____	Policy Number: _____
Diagnosis Code: _____	Precertification: <input type="checkbox"/> Initiated <input type="checkbox"/> Complete
Diagnosis Code Description: _____	Location to be Performed:
	<input type="checkbox"/> Moore Regional Hospital (MRH)
	<input type="checkbox"/> Montgomery Memorial Hospital (MMH)
Interval _____ Day _____ of every _____ month	Next Due Date: _____
Minimum Separation _____ days / weeks (circle one)	Duration: <input type="checkbox"/> Until discontinued <input type="checkbox"/> _____ Treatments
	<input type="checkbox"/> Until _____

Nursing Orders	Interval	Duration
<input type="checkbox"/> Vital Signs Check vital signs before and after each infusion dose and PRN with any change in patient status	_____	_____
<input type="checkbox"/> Insert peripheral IV Once	_____	_____

Picc Access And Flush Orders	Interval	Duration
<input type="checkbox"/> PICC Line Access Once	_____	_____
<input type="checkbox"/> heparin, porcine (PF) 10 unit/mL injection 50 Units 50 Units, intravenous	_____	_____

Vascular Access Device (cvc) Access and Flush Orders	Interval	Duration
<input type="checkbox"/> Central Venous Catheter (CVC) access Once	_____	_____
<input type="checkbox"/> heparin, porcine (PF) injection 500 Units 500 Units, intravenous	_____	_____

Labs – CBC / H&H	Interval	Duration
<input type="checkbox"/> Hemoglobin and hematocrit, blood	_____	_____
<input type="checkbox"/> CBC	_____	_____
<input type="checkbox"/> Ferritin	_____	_____

Pre-Medications	Interval	Duration
<input type="checkbox"/> sodium chloride 0.9 % infusion 500 mL 500 mL, intravenous, at 10 mL/hr, For 1 Dose Carrier Fluid	_____	_____

Provider Signature: _____ **Date:** _____ **Time:** _____

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Medications	Interval	Duration
Venofer-daily		
<input type="checkbox"/> iron sucrose (VENOFER) 100 mg in sodium chloride 100 mL IVPB 100 mg, intravenous, for 30 Minutes, For 1 Dose	_____	_____
<input type="checkbox"/> iron sucrose (VENOFER) 200 mg in sodium chloride 100 mL IVPB 200 mg, intravenous, for 60 Minutes, For 1 Dose	_____	_____

Infusion Reaction Management		
<input type="checkbox"/> Nursing Communication For any adverse reactions, STOP INFUSION IMMEDIATELY and call physician, increase NS infusion rate to brisk flow		
<input type="checkbox"/> diphenhydrAMINE (BENADRYL) injection 25 mg 25 mg, intravenous, For 1 Dose After discharge, instruct patient to take Benadryl 25mg by mouth every 6 hours PRN	_____	_____
<input type="checkbox"/> methylPREDNISolone sodium succinate (Solu-MEDROL) injection 125 mg 125 mg, intravenous, severe hives, flushing and/or hypotension	_____	_____
<input type="checkbox"/> diphenhydrAMINE (BENADRYL) injection 25 mg 25 mg, intravenous, itching, Severe Hives/Flushing/Hypotension, Give with Solumedrol	_____	_____
<input type="checkbox"/> EPINEPHrine (ADRENALIN) injection 0.3 mg 0.3 mg, subcutaneous, anaphylaxis, For 1 Dose	_____	_____

For Scheduling Fax Forms to: (910) 715-1177.

Provider Signature: _____ **Date:** _____ **Time:** _____

* May be used as EPIC Downtime Form