FirstHealth OF THE CAROLINAS

OP Iron Sucrose (Venofer) IV Weekly Referral

3POREF001

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: _____

Patient Name: _____

Patient SSN (if available): _____

Insurance Name: _____

Secondary Insurance: _____

Diagnosis Code: _____

Diagnosis Code Description: _____

Lead Physician _____

Date of Birth: _____

Contact Number: _____

Policy Number: _____

Policy Number: _____

Precertification: ☐ Initiated ☐ Complete

Location to be Performed:

☐ Moore Regional Hospital (MRH)

☐ Montgomery Memorial Hospital (MMH)

Interval _____ Day _____ of every _____ month

Minimum Separation _____ days / weeks (circle one)

Next Due Date _____

Duration: ☐ Until discontinued ☐ ____ Treatments ☐ Until _____

Nursing Orders	**Interval**	**Duration**
☐ Vital Signs Check vital signs before and after each infusion dose and PRN with any change in patient status		
☐ Insert peripheral IV Once	_____	_____
Picc Access and Flush Orders		
☐ PICC Line Access Once	_____	_____
☐ heparin, porcine (PF) 10 unit/mL injection 50 Units 50 Units, intravenous	_____	_____
Vascular Access Device (cvc) Access and Flush Orders		
☐ Central Venous Catheter (CVC) access Once	_____	_____
☐ heparin, porcine (PF) injection 500 Units 500 Units, intravenous	_____	_____
Labs-CBC / H&H		
☐ Hemoglobin and hematocrit, blood	_____	_____
☐ CBC	_____	_____
☐ Ferritin	_____	_____
Pre-Medications		
☐ sodium chloride 0.9 % infusion 500 mL 500 mL, intravenous, at 10 mL/hr, For 1 Dose Carrier Fluid	_____	_____

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

* May be used as EPIC Downtime Form

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Medications		
Venofer - Weekly	**Interval**	**Duration**
☐ iron sucrose (VENOFER) 200 mg in sodium chloride 100 mL IVPB 200 mg, intravenous, for 15 Minutes, For 1 Dose	_____	_____
☐ iron sucrose (VENOFER) 200 mg in sodium chloride 100 mL IVPB 200 mg, intravenous, for 60 Minutes, For 1 Dose	_____	_____
Infusion Reaction Management		
☐ 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	_____	_____
☐ methylPREDNISolone sodium succinate (Solu-MEDROL) injection 125 mg 125 mg, intravenous, severe hives, flushing and/or hypotension	_____	_____
☐ diphenhydrAMINE (BENADRYL) injection 25 mg 25 mg, intravenous, itching, Severe Hives/Flushing/Hypotension, Give with Solumedrol	_____	_____
☐ 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: _____

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