LIFEBRIDGE HEALTH
CARE BRAVELY

INTRAVENOUS IRON ORDER FORM

Patient Label

Patient Name: _____ DOB: _____

Diagnosis: _____ Diagnosis Code: _____ Height: _____

Allergies: _____ Weight: _____

Pre-appointment Lab Results

The following lab tests must be ordered, completed within 90 days of treatment, and results documented prior to appointment. Please fax a copy of the lab results with this order form.

- ☐ Transferrin saturation **Date obtained:** _____ **Result:** _____
- ☐ Ferritin **Date obtained:** _____ **Result:** _____
- ☐ Hemoglobin **Date obtained:** _____ **Result:** _____

☐ **Iron Dextran (Infed®)**

Estimated Total Iron Deficit			
Degree of iron deficiency	**Hgb (g/dL)**	**Iron dextran dose (mg)**	
		Ideal Body Weight < 70kg*	**Ideal Body Weight > 70kg***
No anemia (symptomatic)	Normal	500	1000
Moderate	10-12 (Women)	1000	1500
	10-13 (Men)		
Severe	7 to 10	1500	2000
Critical	< 7	2000	

IBW (males) = 50kg + 2.3kg per inch >60in

IBW (females) = 45.5kg + 2.3kg per inch >60in

****If actual body weight is less than ideal body weight, then use actual body weight. If calculating the dose for an obstetric patient, use the pre-pregnancy weight.***

Test Dose: Iron dextran 25mg in 50mL 0.9% Sodium Chloride, infuse over 10 minutes

☐ Omit test dose (test doses can be omitted for patients who have tolerated a dose of iron dextran within the past 6 months)

After test dose, wait 1 hour. If no reaction, give **premedication(s):**

- ☐ Acetaminophen 650mg PO
- ☐ Methylprednisolone 125mg IVP
- ☐ Other: _____

Treatment Dose:

- ☐ 500 mg in 250mL NS IV over 1 hour
- ☐ 1000 mg in 250mL NS IV over 1 hour
- ☐ 1500 mg in 500mL NS IV over 1.5 hours
- ☐ 2000 mg in 500mL NS IV over 2 hours

☐ **Iron Sucrose (Venofer®)**

- ☐ 200mg in 100mL NS IV over 30 minutes every 48-72 hours x 5 doses total
- ☐ 200mg in 100mL NS IV over 30 minutes weekly x 5 doses total
- ☐ 500mg in 250mL NS IV over 3.5 hours every 48-72 hours x 2 doses total
- ☐ Other: _____

☐ **Ferumoxytol (Feraheme®)** – 510mg in 50mL NS or D5W IV over 15 minutes x 2 doses, separated by 3-8 days

☒ **Hypersensitivity/Anaphylaxis Medications and Extravasation Management (PRN):** Follow Adult Hypersensitivity Protocol as needed per Nursing Protocol for the treatment of allergic/hypersensitivity reaction. Follow established hospital protocol for extravasation.

Physician's Name (Print): _____ Signature: _____ Date: _____

Contact Number: _____ Fax Number: _____

SINAI HOSPITAL
FAX TO: 410-601-4452
410-601-9311
PHONE: 410-601-4779

Wm. E. KAHLERT CANCER CENTER
(CARROLL HOSPITAL)
FAX TO: 410-871-6521
PHONE: 410-871-6400