Corewell Health™

Patient Name	
DOB	
MRN	
Physician	
CSN	

Physician's Orders
IRON DEXTRAN (INFED) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER

Corewell Health Site of Service (select one):

☐ **Blodgett Hospital**
1840 Wealthy St. SE
Grand Rapids, MI 49506
Phone: 616.391.0351
Fax: 616.391.8969

☐ **Gerber Hospital**
230 West Oak St.
Fremont, MI 49412
Phone: 231.924.1305
Fax: 231.924.1798

☐ **Greenville Hospital**
615 S. Bower St.
Greenville, MI 48838
Phone: 616.225.9330
Fax: 616.754.4043

☐ **Helen DeVos Children's Hospital**
35 Michigan St. NE Floor 2
Grand Rapids, MI 49503
Phone: 616.267.1925
Fax: 616.267.1005

☐ **Lemmen Holton Cancer Pavilion**
145 Michigan St. NE Ste 5200
Grand Rapids, MI 49503
Phone: 616.486.6099
Fax: 616.486.6415

☐ **Ludington Hospital**
1 Atkinson Dr.
Ludington, MI 49431
Phone: 231.845.5085
Fax: 231.845.5025

☐ **Neuro Infusion ICCB**
2750 E Beltline Ave. NE
Grand Rapids, MI 49525
Phone: 616.391.0351
Fax: 616.391.8969

☐ **Pennock Hospital**
1009 W Green St.
Hastings, MI 49058
Phone: 269.798.6762
Fax: 269.798.6763

☐ **Reed City Hospital**
4499 S 220th Ave.
Reed City, MI 49677
Phone: 231.832.7105
Fax: 231.832.0195

☐ **Zeeland Hospital**
8333 Felch St.
Zeeland, MI 49464
Phone: 616.748.3640
Fax: 616.748.3690

☐ **Brownstown Infusion Clinic**
19725 Allen Rd. Ste 101
Brownstown Twp, MI 48183
Phone: 734.479.2371
Fax: 734.479.2451

☐ **Dearborn Hospital**
18101 Oakwood Blvd.
Dearborn, MI 48124
Phone: 313.593.5913
Fax: 313.593.5802

☐ **Farmington Hills Hospital Botsford**
28050 Grand River Ave.
Farmington Hills, MI 48336
Phone: 947.521.8174
Fax: 248.471.8217

☐ **Grosse Pointe Infusion Clinic**
21400 E 11 Mile Rd.
Saint Clair Shores, MI 48081
Phone: 586.498.4498
Fax: 586.498.4497

☐ **Lenox Infusion Clinic**
36555 26 Mile Rd. Ste 3300
Lenox, MI 48048
Phone: 947.523.4060
Fax: 947.523.4061

☐ **Livonia Infusion Clinic**
39000 W 7 Mile Rd. Ste 3000
Livonia, MI 48152
Phone: 947.523.4360
Fax: 734.542.3356

☐ **Royal Oak**
3601 W 13 Mile Rd.
Royal Oak, MI 48073
Phone: 248.898.1000
Fax: 248.551.3168

☐ **Troy Hospital**
44344 Dequindre Rd. Ste 230
Sterling Heights, MI 48314
Phone: 248.964.3080
Fax: 248.964.2409

☐ **Wayne Hospital**
33155 Annapolis St.
Wayne, MI 48184
Phone: 734.467.2556
Fax: 734.467.2505

☐ **Marie Yeager Cancer Center**
3900 Hollywood Rd.
Saint Joseph, MI 49085
Phone: 269.556.7180
Fax: 269.556.7185

☐ **Niles Infusion**
42 N St. Joseph Ave. Ste 303
Niles, MI 49120
Phone: 269.684.6140
Fax: 269.683.8744

☐ **Watervliet Hospital**
400 Medical Park Dr.
Watervliet, MI 49098
Phone: 269.463.2310
Fax: 269.463.0012

PATIENT INFORMATION:

Name: First _____ Middle _____ Last _____

Date of birth _____ Phone (_____) _____

Address _____

City _____ State _____ Zip code _____

REFERRAL: Infusion Therapy

Referring Physician (print) _____

Office: Phone (_____) _____ Fax (_____) _____

Direct line for urgent questions about patient (_____) _____

CONTINUED ON PAGE 2 ➔

NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

Corewell Health™

Patient Name
DOB
MRN
Physician
CSN

Physician's Orders
IRON DEXTRAN (INFED) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER *(CONTINUED)*
Page 2 to 3

Infusions

Anticipated Infusion Date: _____ **ICD-10 Code with Description:** _____

Height _____ (cm) Weight _____ (kg) Allergies _____

Labs to be collected

☐ Hemoglobin + Hematocrit (H+H)
- ☐ Every 7 days
- ☐ Once
- ☐ _____

☐ Ferritin, Blood Level
- ☐ Every 7 days
- ☐ Once
- ☐ _____

☐ Transferrin, Blood Level
- ☐ Every 7 days
- ☐ Once
- ☐ _____

☐ Iron and Iron Binding Capacity Level
- ☐ Every 7 days
- ☐ Once
- ☐ _____

☐ Additional lab order(s) _____
- ☐ Every 7 days
- ☐ Once
- ☐ _____

Pre-medications

☐ Acetaminophen (TYLENOL) PO ☐ 325 mg ☐ 500 mg ☐ 650 mg ☐ 1000 mg

☐ MethylPREDNISolone (SOLU-Medrol) IV ☐ 40 mg ☐ 60 mg ☐ 80 mg ☐ 125 mg

☐ Additional pre-medications: _____
☐ Once ☐ Every 7 days ☐ _____

Treatment

☒ Iron dextran complex (INFED) IVPB
- ☐ 100 mg every 7 days for 10 doses
- ☐ 100 mg every 7 days for _____ doses
- ☐ 1000 mg ONCE
- ☐ _____ mg every _____ days for _____ doses

A TEST DOSE of 25 mg will be given over 5 minutes prior to starting iron dextran therapy. Must wait at least 1 hour after test dose before administering remainder of dose.

Doses less than or equal to 100 mg should be infused over at least 15 min. Doses greater than 100 mg administer over 1 to 3 hours.

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

CONTINUED ON PAGE 3 ➔

Corewell Health™

Patient Name	
DOB	
MRN	
Physician	
CSN	

Physician's Orders
IRON DEXTRAN (INFED) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER *(CONTINUED)*

Supplemental Orders

*****The following orders will be applied to the patient's plan unless otherwise indicated*****

Appointment Requests

☒ **Infusion Appointment Request**
Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after injection and possible labs

Provider Ordering Guidelines

☒ **PROVIDER REMINDER**
Dose (mL) = 0.0442 (desired HGB - observed HGB) x LBW + (0.26 x LBW); Dose (mg) = dose (mL) x 50 mg/mL.

LBW = lean body weight (kg); HGB = hemoglobin (g/dL)

If dose exceeds 1000 mg, remaining dose may be given after 4 weeks if adequate hemoglobin response

Provider Reminder

☒ **ONC PROVIDER REMINDER 2**
Repeat iron study labs should be ordered outside of the therapy plan.

Nursing Orders

☒ **ONC NURSING COMMUNICATION 10**
Iron Dextran - hypersensitivity reaction: Monitor for hypersensitivity reactions during administration and for 30 minutes after administration of first dose or with every dose if history of infusion reaction. Anaphylactic-type reactions have been reported (use only where resuscitation equipment and personnel are available). A test dose should be administered to all patients prior to the first therapeutic dose. Anaphylactic and other hypersensitivity reactions have occurred even in patients who tolerated the test dose; observe for anaphylactic reactions during any iron dextran administration; fatalities have occurred with the test dose. A history of drug allergy (including multiple drug allergies) and/or the concomitant use of an ACE inhibitor may increase the risk of anaphylactic-type reactions.

Delayed (1-2 days) infusion reaction (including arthralgia, back pain, chills, dizziness, and fever) may occur with large doses (eg, total dose infusion) of IV iron dextran; usually subsides within 3-4 days.

☒ **ONC NURSING COMMUNICATION 20**
If patient develops adverse reaction STOP INFUSION IMMEDIATELY and Notify Provider.

☒ **ONC NURSING COMMUNICATION 9**
Check that labs indicated for THIS Treatment Cycle have been drawn within the last 96 hours or draw them in clinic prior to beginning treatment.

☒ **ONC NURSING COMMUNICATION 200**
May Initiate IV Catheter Patency Adult Protocol

☒ **Hypersensitivity Reaction Adult Oncology Protocol**
Until discontinued Starting when released Until Specified

Vitals

☒ **Vital Signs**
Routine, PRN Starting when released Until Specified
Vital Signs: Routine vital signs per policy.

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

Telephone order/Verbal order documented and read-back completed. Practitioner's initials _____

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.

TRANSCRIBED:		**VALIDATED:**		**ORDERED:**			
TIME	**DATE**	**TIME**	**DATE**	**TIME**	**DATE**	Pager #	
	Sign		**R.N. Sign**		**Physician Print**		**Physician Sign**

 © Corewell Health