

Physician's Orders

FERRIC GLUCONATE (FERRLECIT) -

ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER

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Corewell Health Site of Service (select one):

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Blodgett Hospital
1840 Wealthy St. NE
Grand Rapids, MI 49506
Phone: 616.391.0351
Fax: 616.391.8969 | <input type="checkbox"/> Gerber Hospital
230 West Oak St.
Fremont, MI 49412
Phone: 231.924.1305
Fax: 231.924.1798 | <input type="checkbox"/> Greenville Hospital
615 S. Bower St.
Greenville, MI 48838
Phone: 616.225.9330
Fax: 616.754.4043 | <input type="checkbox"/> Helen DeVos Children's Hospital
100 Michigan St. NE
Grand Rapids, MI 49503
Phone: 616.267.1925
Fax: 616.267.1005 |
| <input type="checkbox"/> Lemmen Holton Cancer Pavilion 145 Michigan St. NE
Grand Rapids, MI 49503
Phone: 616.486.6099
Fax: 616.486.6415 | <input type="checkbox"/> Ludington Hospital
1 Atkinson Dr.
Ludington, MI 49431
Phone: 231.845.5085
Fax: 231.845.5025 | <input type="checkbox"/> Neuro Infusion ICCB
2750 E Beltline Ave NE
Grand Rapids, MI 49525
Phone: 616.391.0351
Fax: 616.391.8669 | <input type="checkbox"/> Pennock Hospital
1009 W. Green St.
Hastings, MI 49058
Phone: 269.798.6762
Fax: 269.798.6763 |
| <input type="checkbox"/> Reed City Hospital
4499 220 th Ave.
Reed City, MI 49677
Phone: 231.832.7105
Fax: 231.832.0915 | <input type="checkbox"/> Zeeland Hospital
8333 Felch St.
Zeeland, MI 49464
Phone: 616.748.3640
Fax: 616.748.3690 | | |

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Brownstown Infusion Clinic
19725 Allen Rd. Suite 101
Brownstown Twp, MI 48183
Phone: 734.479.2371
Fax: 734.479.2451 | <input type="checkbox"/> Dearborn Hospital
18101 Oakwood Blvd.
Dearborn, MI 48124
Phone: 313.593.5913
Fax: 313.593.8551 | <input type="checkbox"/> Farmington Hills Hospital Botsford
28050 Grand River Ave.
Farmington Hills, MI 48336
Phone: 947.521.8174
Fax: 248.471.8217 | <input type="checkbox"/> Grosse Pointe Infusion Clinic
21400 E 11 Mile Rd.
Saint Clair Shores, MI 48081
Phone: 586.498.4498
Fax: 586.498.4497 |
| <input type="checkbox"/> Lenox Infusion Clinic
36555 6 Mile Rd.
Lenox, MI 48048
Phone: 947.523.4060
Fax: 947.523.4061 | <input type="checkbox"/> Livonia Infusion Clinic
39000 7 Mile Rd. Suite 1000
Livonia, MI 48152
Phone: 947.523.4360
Fax: 734.542.3356 | <input type="checkbox"/> Royal Oak
3601 W 13 Mile Rd.
Royal Oak, MI 48073
Phone: 248.898.1000
Fax: 248.551.3168 | |
| <input type="checkbox"/> Troy Hospital
44344 Dequindre Rd. Suite 230
Sterling Heights, MI 48314
Phone: 248.964.3080
Fax: 248.964.2409 | <input type="checkbox"/> Wayne Hospital
33155 Annapolis St.
Wayne, MI 48184
Phone: 734.467.2556
Fax: 734.467.2505 | | |

- | | | |
|--|--|---|
| <input type="checkbox"/> Marie Yeager Cancer Center
3900 Hollywood Rd.
Saint Joseph, MI 49085
Phone: 269.556.7180
Fax: 269.556.7185 | <input type="checkbox"/> Niles Infusion
42 N St. Joseph Ave Ste 303
Niles, MI 49120
Phone: 269.684.6140
Fax: 269.683.8744 | <input type="checkbox"/> 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 (____) _____

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

FERRIC GLUCONATE (FERRLECIT) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER (CONTINUED)

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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

☐ _____

☐ Iron and Iron Binding Capacity Level

☐ Every 7 days

☐ Once

☐ _____

☐ Reticulocyte Count with Reticulocyte Hemoglobin

☐ Every 7 days

☐ Once

☐ _____

☐ Additional lab order(s) _____

☐ Every 7 days

☐ Once

☐ _____

Pre-medications:

☐ Diphenhydramine (BENADRYL) PO Once ☐ 25 mg ☐ 50 mg

☐ Methylprednisolone sodium succinate (SOLU-Medrol) IV Once ☐ 40 mg ☐ 60 mg ☐ 80 mg ☐ 125 mg

☐ Additional Pre-medications: _____

Treatment

Frequency:

☐ Once

☐ Every 7 days

☐ Every _____ days

Duration:

☐ 8 Treatments

☐ # of treatments _____

☐ Until date: _____

☒ Ferric gluconate (FERRLECIT) 125 mg IVPB

Administer over 60 minutes



Patient Name

DOB

MRN

Physician

CSN

FERRIC GLUCONATE (FERRLECIT) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER (CONTINUED)

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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

Nursing Orders

☒ **ONC NURSING COMMUNICATION 10**

Ferric Gluconate - 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. Serious hypersensitivity reactions, including anaphylactic-type reactions, have occurred (may be life-threatening). May present with shock, clinically significant hypotension, loss of consciousness, or collapse. Avoid rapid administration. Equipment for resuscitation and trained personnel experienced in handling medical emergencies should always be immediately available.

Use only in patients with documented iron deficiency.

☒ **ONC NURSING COMMUNICATION 100**

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:		Pager #
TIME	DATE	TIME	DATE	TIME	DATE	
Sign		R.N. Sign		Physician Print		Physician Sign

EPIC VERSION DATE:

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