smartinfusion THERAPY SERVICES

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www.MySmartInfusion.com

Venofer (iron sucrose)

Infusion Order Form

Location

☐ Eau Claire ☐ Weston
☐ Middleton

Patient Information

Patient Name: _____DOB: _____ M ☐ F ☐

Allergies: _____

☐ New Treatment ☐ Continuing Treatment Last Treatment Date: _____ Next Due Date: _____

Diagnosis and ICD 10 Code (Required)

☐ Iron deficiency anemia ICD 10 Code: D50.9

☐ Anemia in Chronic Kidney Disease ICD 10 Code: D63.1

Required Tests

Pregnancy Test Status & Date: _____

Required Labs

Most recent Hgb & iron panel (attach results)

Pre-Medication Orders

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO

Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ **PO** ☐ **IV**

Methylprednisolone (Solu-Medrol) ☐ 125mg IV

Ondansetron (Zofran) ☐ 4mg ☐ **PO** ☐ **IV**

Other: _____ Route: _____

Dose: _____ Frequency: _____

Venofer Medication Order

Dose (choose one):

☐ 100 mg 100ml NS 200 ml/hr 30 minutes ¨
☐ 200 mg 200ml NS 200 ml/hr 60 minutes ¨
☐ 300 mg 250 ml NS 166.6 ml/hr 90 minutes
30 minute post observation time

Frequency:

☐ Once
☐ Every 2-3 days x_____ doses
☐ Daily x _____ doses
☐ Weekly x _____ doses
☐ Monthly x _____ doses

Adverse Reaction Management & Nursing Orders

Full protocols are available for review at mysmartinfusion.com or upon request.

☒ Administer the following emergency medications per Smart Infusion Therapy Services protocol:
- ☒ Acetaminophen 650mg PO,
- ☒ Diphenhydramine 25mg-50mg PO or IV
- ☒ Ondansetron 4mg IV
- ☒ Sodium Chloride 0.9% 1000mL IV
- ☒ Methylprednisolone 125mg IV
- ☒ Albuterol Sulfate 2.5mg nebulized
- ☒ Oxygen 1-6LPM continuous flow
- ☒ Epinephrine 0.3mg/0.3mL IM

☐ Other: _____

☒ Manage VAD per protocol:

☒ Start/Access and Discontinue PIV/CVC

☒ Flush with NS and/or Heparin per protocol based on line type

☒ Other: _____

Required Documents

- ☐ Patient Demographic Sheet
- ☐ H & P within the past 6 months
- ☐ Current Medication List
- ☐ Clinical & Progress Notes (including last infusion note)
- ☐ Copy of Insurance Card (Front/Back)

Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____