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 in 100ml 0.9NS over 15 minutes
☐ 200 mg in 200ml 0.9NS over 15 minutes
☐ 300 mg in 250 ml 0.9NS over 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: _____