AFFIX LABEL HERE

Medical Day Clinic - Iron Sucrose (Venofer®) Infusion Order Set

*** Order valid for 6 months only***

Most Responsible Physician ______________________ **Code Status:** ☐ Full ☐ DNR ☐Other__________________

Referring Physician/MRP to:

- **Provide patient with prescription for Iron Sucrose and instruct to bring medication to appointment**
- **Be available or designate for contact if any adverse reactions occur during administration**

Allergies: ☐ NKA or ____

☒ Ensure consent has been obtained prior to initiation of transfusion

Indications: Reason for Iron Deficiency:____

IV Therapy

☒ If no existing IV, initiate IV saline lock

Vitals

☒ Baseline T, HR, RR, BP, SpO_2 prior to infusion, q30 minutes until 1 hour post completion of infusion

Iron SUCROSE (Venofer®)

*** Cumulative maximum dose 1,000 mg. Total dose not to be administered in a period of time less than 14 days***

☒ Hold iron sucrose if Temperature is greater than 38°C and/or if patient is currently taking PO or IV antibiotics

Iron Sucrose IV (maximum rate 100 mg/h, dose not to exceed 300 mg)

☐ iron sucrose 100 mg in 100 mL 0.9% NaCl IV infused over 1 hour

OR

☐ iron sucrose 200 mg in 100 mL 0.9% NaCl infused over 2 hours

OR

☐ iron sucrose 300 mg in 250 mL 0.9% NaCl infused over 3 hours

Frequency

☐ Number of doses: __________ doses to be given: _________ days apart (max 6 months)

Management of Side Effects

☒ **If Adverse Reaction** (Hypotensive reaction - systolic blood pressure drop of 25 mmHg, phlebitis and venous spasm, abdominal cramps, leg cramps, nausea, diarrhea)

- ☒ Hold infusion x 30 minutes
- ☒ If symptoms improve resume infusion at half previous rate
- ☒ If symptoms persist give 500 mL 0.9% NaCl bolus and call physician

☒ **If anaphylactic reaction occurs:**

- ☒ Stop infusion immediately
- ☒ Notify MD
- ☒ **EPINEPH**rine 0.5 mL of 1 mg/mL ampoule IM STAT
- ☒ Start O_2 at 35-50% by mask
- ☒ diphenhydr**AMINE** 50 mg IV STAT

______________________	______________________	___________	___________
Physician/Practitioner Signature	Print Name/Designation	Date	Time

Transcribed By: ______________________ Designation ______________________ Date ___________ Time _________

Checked By: ______________________ Designation ______________________ Date ___________ Time _________

☐ Sent to Pharmacy Date ______________ Time ___________