



**MEDICAL DAY CARE – ADULT  
INTRAVENOUS IRON ORDERS**

CLERK	NURSE	ORDER SET: N/A
		<p>1. Hemoglobin _____ g/L (Date of blood work : _____ )  <del>/s/</del> Ferritin _____ ng/mL  <b>(Note: Medical Day Care will only transfuse if Hemoglobin is less than or equal to 120 g/L and/or Ferritin level less than or equal to 100 ng/mL. Bloodwork must be done with 4 weeks of ordered infusion)</b></p> <p>2. <input type="checkbox"/> Iron Sucrose 100 mg in 100 mL NS IV over _____ (minimum duration: 15 mins)  <del>/s/</del> <input type="checkbox"/> Iron Sucrose 200 mg in 100 mL NS IV over _____ (minimum duration: 15 mins)  <input type="checkbox"/> Iron Sucrose 300 mg in 250 mL NS IV over _____ (minimum duration: 1.5 hrs)  <input type="checkbox"/> Repeat every _____ weeks for a total of _____ doses <b>(Maximum 3 doses will be infused before new bloodwork and order required).</b></p> <p>3. <b>Patient's own supply of Iron isomaltoside must be arranged prior to ordering.</b>  <del>/s/</del> <input type="checkbox"/> Iron Isomaltoside 500 mg IV in 100 mL NS IV over 20 minutes  <input type="checkbox"/> Iron Isomaltoside 1000 mg IV in 100 mL NS IV over 20 minutes  <input type="checkbox"/> Iron Isomaltoside 1500 mg IV in 100 mL NS IV over 30 minutes  <input type="checkbox"/> Iron Isomaltoside 1500 mg IV in 100 mL NS IV over 30 minutes followed by:  Iron Isomaltoside 500 mg IV in 100 mL NS IV over 20 minutes 7 days later</p> <p>4. Vital signs  <ul style="list-style-type: none"> <li>• q15 mins x 4; then q1 hour until completed</li> <li>• 30 mins post infusion</li> </ul> Notify physician of current antibiotic use or acute infection prior to proceeding with infusion/ injection  If temperature is greater than 38°C, then contact the physician before proceeding with iron administration  Observe patient for signs and symptoms of hypersensitivity during and for at least 30 minutes after iron administration</p>
24 hr		<p>5. For any reaction, CALL ordering physician (or covering physician) STAT and give appropriate medications from below.  Acetaminophen 325 - 650 mg PO/PR x 1 PRN  Diphenhydramine 25 - 50 mg PO/IV x 1 PRN  Dimenhydrinate 25 - 50 mg PO/IV x 1 PRN  Famotidine 20 mg PO/IV x 1 PRN  Other: _____</p>

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ M.D. SIGNATURE: \_\_\_\_\_

STAKEHOLDER REVIEW & APPROVAL

This section provides evidence that the Head of Dept has reviewed and approved the content



<b>Head of Dept</b>	<b>Date</b>
Dr. David Boyle, Medical Director, Surgical Program	Oct 2019