

Pediatric Venofer Infusion Order (Revised 4/3/21)

Instructions to Provider: All orders with will be placed unless otherwise noted. Please fax completed order, along with referral form.

Required Lab Results: CBC performed within 4 months prior to treatment. Hold for Hgb greater than 10 (if outside of Atrium, please fax with order. Required prior to scheduling.)

Infusion Therapy:

Venofer (iron sucrose) _____mg IV over 60 minutes

Frequency: _____

ICD 10 code: _____

Pre-Meds: Administer 30 minutes prior to Venofer

Acetaminophen _____ mg PO x 1

Benadryl _____ mg PO or _____mg IV x 1 (*if applicable, only choose ONE*)

SoluMedrol _____ mg IV x 1

Famotidine _____mg IV x 1

EMLA cream prior to IV start

Anaphylaxis Medications:

Epinephrine (1:1000) _____ mg SQ/IM; may be repeated after 5mins

SoluMedrol _____mg IV

Benadryl _____mg IV

Additional Orders:

Special Instructions:

- Follow Atrium Health Infusion Center protocol for hypersensitivity PRN.

Infusion Monitoring:

- Obtain vital signs pre- and post-infusion. Obtain vital signs PRN during infusion.
- Monitor for signs of reaction for 30mins after completion of the infusion.

Physician Name: _____

Physician Signature: _____

Date: _____ (Order valid for 1 year)

Patient Name:

DOB:

MRN: