Columbus Community Hospital
Columbus, Nebraska
DOCTORS ORDERS

PLEASE NOTE: Condition of Wound, Removal of Stitches, Consultation, Change in Diagnosis, Complications, Condition on Discharge, Instructions of Patient.

PLEASE SIGN AND DATE EACH ENTRY

PLEASE INDICATE / ALLERGIES

NONE	CODEINE	PENICILLIN	SULFA	ASPIRIN	OTHER	HEIGHT
REACTION						WEIGHT

Authorization is granted to supply medications by non-proprietary name unless checked here ☐

PHYSICIANS ORDERS
(including Medications)

Iron Sucrose (Venofer) Orders **2/2024**

1. Diagnosis_____

2. Treatment Start Date: _____ Date to follow up with provider, if needed: _____

3. **If not from CCH physician, send Face Sheet and H&P or most recent chart note.**

4. **Premedications** prior to Iron Infusion:

☐ Acetaminophen 975mg PO x 1

OR

☐ Acetaminophen (Ofirmev) 1000mg IV x 1

☐ **History of** Transfusion Reaction: Solu-Medrol 125mg IV x 1.

5. **Dose (choose one):**

☐ Iron Sucrose 100mg diluted in 100mL of 0.9% NaCL infused over 15 minutes IVPB x 1.

☐ Iron Sucrose 200mg diluted in 250mL of 0.9% NaCL infused over 30 minutes IVPB x 1.

☐ Iron Sucrose 200mg diluted in 250mL of 0.9% NaCL infused over 30 minutes IVPB x 2.
on date: _____ & date: _____

☐ Iron Sucrose 300mg diluted in 250mL of 0.9% NaCL infused over 90 minutes IVPB x 1.

☐ Iron Sucrose 300mg diluted in 250mL of 0.9% NaCL infused over 90 minutes IVPB x 2.
on date: _____ & date: _____

☐ Iron Sucrose _____mg IVPB x 1 (dilution and infusion rate per pharmacy).

6. Nursing orders:

- Vitals prior to and after infusion
- Start IV saline lock or access implanted port per facility protocol.
- Patient should be reclined or semi-reclined during administration
- Monitor patient for 30 minutes after infusion. DO NOT discontinue IV until after 30 minutes of monitoring.

☐ Labs to be drawn: _____

7. If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider.

Administer emergency medications per CCH Infusion Center Hypersensitivity Orders
OR per the following order: _____

Provider signature: _____ Date/Time: _____

Printed Name: _____ Phone: _____ Fax: _____