UNIVERSITY of MARYLAND MEDICAL CENTER
KAUFMAN INFUSION CENTER

Patient Name: _____
DOB: _____

Provider Orders for:
Ferrlecit Infusion

☐ = ***must*** **check off to order / ☑ *automatically* initiated unless crossed out**

DATE: _____ **TIME:** _____ **WEIGHT** _____ **kg** **HEIGHT** _____ **cm**

Diagnosis: Iron deficiency anemia **ICD-10:** _____

This order is good for _____ # months or until _____ (date).

☑ Height and Weight on Admission

☑ Vital Signs per protocol

☑ Oxygen 2L/min via nasal cannula PRN dyspnea

Tests: **(Obtain the following test results prior to Patient arrival to the Infusion Center)**

☐ CBC ☐ Ferritin ☐ TIBC/Fe

IV Line Patency Maintenance for:

☑ NS IV 250 mL at 30 mL/hr

☑ 3 mL heparin 100 units/mL IV flush PRN central line maintenance; max 3 doses/24hr

Supportive Medications:

☐ dexamethasone (Decadron) ☐ 12 mg or ☐ 20 mg ☐ IVPB or ☐ PO Before Ferrlecit

☐ diphenhydrAMINE (Benadryl) ☐ 25 mg or ☐ 50 mg ☐ IVPB or ☐ PO Before Ferrlecit

Other Medications: _____

Treatment Order	Total Daily Dose	Route	Schedule
☐ Ferrlecit	125 mg	IVPB in 100 mL NS over 60 minutes	Weekly times 8 weeks
☐ Ferrlecit	250 mg	IVPB in 250 mL NS over 2 hours	Weekly times 4 weeks
*****Maintain direct observation of patient for 30 minutes post Ferrlecit infusion*****			

Other Orders: _____

_____

Authorized Prescriber Signature: _____ Date: _____ Time: _____
(for verbal/telephone orders)