**Infusion Services – Referral Form**
200 Terrace Hill St.
Brantford, ON
N3R 1G9
**519-751-5544 ext. 5520**
**FAX: 519-751-5569**

| | | |
|---|---|---|
| **Patient Info** | Name: Address: | |
| | Phone: D.O.B: H.C.: | |
| **Medical History** | ☐ Cardiac ☐ Diabetes ☐ Seizure ☐ Renal ☐ Hepatic<br>**** Patients to bring routine medication (e.g. Insulin) with them on day of treatment **** | |
| **Reason for Referral** | | |
| **Service Required** | ☐ Therapeutic Phlebotomy<br>**(Please indicate quantity and frequency of Therapeutic Phlebotomy until goal is reached.)** | ☐ Iron Infusion<br>**(Referring MD to provide Pt with prescription To be filled prior to coming to Clinic and Instruct Pt to bring medication to appointment)** |
| **Orders** | *COMPONENT REQUIRED _____<br>☐ Irradiated Blood (infusion clinic will confirm delivery date and communicate booking)<br>☐ CBC<br>**Patient is known to have antibodies ☐ Yes ☐ No ☐ Unknown**<br>☐ Give ____ units PRBC **Infuse EACH unit over 2 - 3 hours**<br>Furosemide: ___mg □ IV □PO □between units of PRBC □after each unit PRBC □PRN □Not required<br>***** BLOOD TRANSFUSION –it is recommended that crossmatch and CBC be drawn 1 to 2 days prior to transfusion appointment<br>****** Patients requiring **more than 2 units will receive service on more than 1 visit** due to time of infusions **<br>Patients with known antibodies **will require type and screen at least 3 days prior** to infusion to allow time to prepare blood products **<br>**BLOOD DRAWN by OUTSIDE LAB** Cross match blood work Collection Date:_____<br>If crossmatch collected by community lab in advance of infusion appointment please fax this referral to the Brant Community Healthcare System lab at **(519) 752-7809** | |
| **Barriers** | ☐ Physical ☐ Cognitive / Language (Interpreter/family should attend) Comments: | |
| **Physician Info** | Name:<br>Physician signature:<br>Date: | Phone: / Fax: |
| *(Office Use)* **Appt. Time and Date** | | **Notified To:**<br>**Date:**<br>**Time:** **Initials:** |

**Once referral is received REFERRING PHYSICIAN will be contacted with an appointment date and time for service. Patients must have an appointment to ensure they can receive service.**
**** * * Due to volume and acuity same day appointments are not available * * ****

THE BRANT COMMUNITY HEALTHCARE SYSTEM
Brantford General Hospital Site
ORDER SHEET

**HT :** _____ **WT :** _____

# NON-DIALYSIS IV IRON SUCROSE (VENOFER) PREPRINTED ORDERS



**LAB**
X Baseline hemoglobin (Hgb) and Ferritin **PRIOR** to first infusion: Hgb_____ Ferritin _____
Draw CBC, ferritin prior to each infusion

**MUST BE COMPLETED BEFORE FAXING**

**CONSENT**
X Ensure consent is signed, dated, witnessed on chart

**MONITORING**
X Record Vital signs pre-transfusion and Q15 minutes x2, post-transfusion PRN.

**PREPARATION**
X Insert saline lock
X 1 mL of 1:1000 EPINEPHrine IV injection and methylPREDnisolone 125 mg IV injection on hand X Mix iron sucrose (Venofer) 200 mg dose in 100-250cc N-S

**MEDICATION/ADMINISTRATION**
Give 15 min prior to IV iron, if applicable: *(Ordering Physician to check box below, if needed)* dexamethasone 10 mg PO for high risk only *(e.g. previous infusion reaction, immune or inflammatory conditions such as systemic lupus or rheumatoid arthritis, severe asthma/eczema/atopic allergy, multiple drug allergies)*
X Begin each iron sucrose infusion at 40 mL/hr for 15 minutes. If tolerated, infuse remainder of dose at 200 mL/hr. Refer to dosing table.

| Hemoglobin (g/L) | Patient Weight | Dose |
|---|---|---|
| Female: More than 120 | Less than 70 kg | 200 mg x 3 doses (total 600 mg) |
| Male: More than 130 | 70 kg or more | 200 mg x 5 doses (total 1000 mg) |
| Female: 100 to 120 | Less than 70 kg | 200 mg x 5 doses (total 1000 mg) |
| Male: 100 to 130 | 70 kg or more | 200 mg x 7 doses (total 1400 mg) |
| 70 to 99 | Less than 70 kg | 200 mg x 7 doses (total 1400 mg) |
| 70 to 99 | 70 kg or more | 200 mg x 10 doses (total 2000 mg) |
| Less than 70 | Less than 70 kg | 200 mg x 10 doses (total 2000 mg) |
| Less than 70 | 70 kg or more | 200 mg x 12 doses (total 2400 mg) |

**Total dose indicated by MD.**

X After infusion, flush vein with 10 mL of N-S, observe patient for 30 minutes, then discharge home if stable
X If reaction occurs:
a) Stop infusion
b) Call ordering physician
X Prepare to give IV methylPREDNISolone 125 mg (confirm dose with ordering physician)
**** If any problems, discontinue IV iron, and call Ordering Physician and/or Internist-On-Call and/or Code Blue*

**FOLLOW UP**
Re-Book infusion services weekly and PRN.

**Physician must be available by telephone in case of emergency/reaction.**

Signature: _____ Date:_____Time:_____
Printed Signature (dd/mm/yy) (hh:mm)