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 **** Patients to bring routine medication (e.g. Insulin) with them on day of treatment ****	
Reason for Referral		
Service Required	☐ Therapeutic Phlebotomy **(Please indicate quantity and frequency of Therapeutic Phlebotomy until goal is reached.)**	☐ Iron Infusion **(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 _____ ☐ Irradiated Blood (infusion clinic will confirm delivery date and communicate booking) ☐ CBC **Patient is known to have antibodies ☐ Yes ☐ No ☐ Unknown** ☐ Give ____ units PRBC **Infuse EACH unit over 2 - 3 hours** Furosemide: ___mg □ IV □PO □between units of PRBC □after each unit PRBC □PRN □Not required ***** BLOOD TRANSFUSION –it is recommended that crossmatch and CBC be drawn 1 to 2 days prior to transfusion appointment ****** Patients requiring **more than 2 units will receive service on more than 1 visit** due to time of infusions ** Patients with known antibodies **will require type and screen at least 3 days prior** to infusion to allow time to prepare blood products ** **BLOOD DRAWN by OUTSIDE LAB** Cross match blood work Collection Date:_____ 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: Physician signature: Date:	Phone: / Fax:
(Office Use) **Appt. Time and Date**		**Notified To:** **Date:** **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)