



PROVIDENCE Health & Services

ADULT AMBULATORY INFUSION ORDER
POHYPERS-06/21

HEPERSENSITIVITY INFUSION REACTION ORDERS

NAME:
BIRTHDATE:
INSURANCE:
PROVIDER NAME:
CLINIC NAME and Phone number:

Patient identification

STOP infusion if:

MILD REACTION: Localized pruritus, rhinitis, localized rash, fever greater than 38 degrees C.

1. Stop infusion and maintain IV access with NS line.
2. Notify MD of symptoms and infusion reaction orders initiated.

MODERATE REACTION: Generalized pruritus, generalized flushing, rash, back pain, mild dyspnea, chills, hypotension with SBP less than 90 mmHg or greater than 20% decrease in SBP.

1. Stop infusion, but do not discard infusion bag/bottle unless instructed by MD that therapy is to be discontinued.
2. Maintain IV access with NS line.
3. Place patients in a supine position with lower extremities elevated unless respiratory distress or nausea/vomiting.
4. Maintain airway.

SEVERE REACTION: Respiratory distress (bronchospasm, stridor, wheezing, persistent cough, respiratory depression, cardiac arrhythmia, chest pain, generalized urticarial (hives), syncope, gastrointestinal symptoms (abdominal pain, N/V, diarrhea), hypotension SBP less than 80 mmHg, face/throat/tongue swelling, shock, loss of consciousness.

1. Stop infusion, but do not discard bag/bottle unless instructed by MD that therapy is to be discontinued.
2. Stay with patient and have another nurse notify MD of symptoms and infusion reaction orders initiated.
3. Place patients in supine position with lower extremities elevated unless respiratory distress or nausea/vomiting.
4. Maintain airway.
5. Maintain IV access with NS line.
6. Inpatients: Activate code blue for loss of blood pressure, pulse, or consciousness.

MEDICATIONS:

- Acetaminophen (TYLENOL) tablet 650 mg, Oral, EVERY 4 HOURS PRN, Pain, Other, Mild reaction. Starting when released.
- Diphenhydramine (Benadryl) injection, 25 mg, Intravenous, EVERY 15 MIN PRN, Moderate or severe reaction, may repeat x1. Starting when released, For 2 doses.
- Methylprednisolone sodium succinate (solu-MEDROL) 62.5mg/ml injection, 125 mg, Intravenous, ONCE PRN, Severe reaction. Starting when released, For 1 dose. Mix with 2 mL provided diluent to make 62.5 mg/mL.
- Famotidine (PEPCID) injection 20 mg, Intravenous, ONCE PRN, Moderate reaction, or anaphylaxis, starting when released. Dilute 2 mL of famotidine with 8 mL of normal saline to a final concentration of 2 mg/mL. Administer ordered dose over a period of at least 2 minutes.
- Albuterol 90 mcg/puff inhaler 2 puff, Inhalation, ONCE PRN, Severe reaction p. Starting when released, For 1 dose. Shake well. Use with spacer.



PROVIDENCE Health & Services

ADULT AMBULATORY INFUSION ORDER
POHYPERS-06/21

HEPERSENSITIVITY INFUSION REACTION ORDERS

NAME:
BIRTHDATE:
INSURANCE:
PROVIDER NAME:
CLINIC NAME and Phone number:

Patient identification

- Start oxygen. For *MODERATE* Reaction: Start 2 liters O2 per nasal cannula as needed for SpO2 less than 93%. For *SEVERE* Reaction: Start continuous pulse oximetry. Administer 6 to 8 liters per minute (LPM) via face mask, or up to 100% oxygen to maintain oxygen saturation greater than 90%.
- EPINEPHrine 1 mg/mL injection 0.3 mg. intramuscular, EVERY 5 MIN PRN, Anaphylaxis. Starting when released, For 3 doses. Administer in the anterior lateral thigh using 1 - 1.5-inch needle for airway obstruction symptoms and/or hypotension.
- Sodium chloride 0.9% (NS) infusion 500ml. At 500 mL/hr, intravenous, PRN, Moderate reaction, or anaphylaxis. Starting when released. Run wide open to gravity

Note to prescribers:

The above instructions and orders for hypersensitivity reactions are considered active and valid if this attachment is accompanying an infusion order form

X _____ Date: _____



PROVIDENCE Health & Services

ADULT AMBULATORY INFUSION ORDER
POHYPERS-06/21
HEPERSENSITIVITY INFUSION REACTION ORDERS

NAME:
BIRTHDATE:
INSURANCE:
PROVIDER NAME:
CLINIC NAME and Phone number:

Patient identification

By signing below, I represent the following:

I am responsible for the care of the patient (*who is identified at the top of this form*).

I hold an active, unrestricted license to practice medicine in Oregon.

My physician license Number is # _____ **(MUST BE COMPLETED TO BE A VALID PRESCRIPTION)**; and I am acting within my scope of practice and authorized by law to order infusion of the medications and blood products described above for the patient identified on this form.

Provider's printed name: _____

Provider's signature: _____

Date: _____

Outpatient Infusion Services Intake Team:

Please check the appropriate box for the patient's preferred infusion center location:

Outpatient Infusion Services

- | | | |
|---|--------------------|------------------|
| <input type="checkbox"/> PORTLAND | Phone 503-215-6046 | Fax 503-487-3582 |
| <input type="checkbox"/> WILLAMETTE FALLS | Phone 503-215-6046 | Fax 503-487-3582 |
| <input type="checkbox"/> MEDFORD | Phone 541-732-7048 | Fax 541-732-3939 |
| <input type="checkbox"/> HOOD RIVER | Phone 541-387-1338 | Fax 541-387-6137 |
| <input type="checkbox"/> SEASIDE | Phone 503-717-7671 | Call for fax # |
| <input type="checkbox"/> NEWBERG | Phone 503-537-1450 | Fax 503-537-1449 |

Reviewed 8/27/21 R Grabowski

Reviewed 9/13 by CVD



PROVIDENCE

Health & Services

ADULT AMBULATORY INFUSION ORDER

POIRONSUC-06/21

IRON SUCROSE (VENOFER) Infusion

NAME:
BIRTHDATE:
INSURANCE:
PROVIDER NAME:
CLINIC NAME and Phone number:

Patient identification

Weight: _____ kg Height: _____ cm Allergies: _____ Diagnosis Code: _____
Treatment Start Date: _____

****These orders will expire after 365 days; new orders are needed after the expiration date****

GUIDELINES FOR ORDERING

1. Send FACE SHEET and H&P or most recent chart note.

MEDICATIONS: (must check one)

Iron sucrose (VENOFER): (must check one)

- 100 mg in sodium chloride 0.9% 100 mL, intravenous, ONCE, over 30 minutes
- 200 mg in sodium chloride 0.9% 100 mL, intravenous, ONCE, over 30 minutes
- 300 mg in sodium chloride 0.9% 250 mL, intravenous, ONCE, over 1.5 hours
- 400 mg in sodium chloride 0.9% 250 mL, intravenous, ONCE, over 2.5 hours
- 500 mg in sodium chloride 0.9% 250 mL, intravenous, ONCE, over 3.5 hours

Interval: (must check one)

- Once.
- Daily x _____ doses.
- Every other day x _____ doses.
- Every _____ weeks x _____ doses.
- Monthly x _____ doses
- Other: _____.

AS NEEDED MEDICATIONS:

- Sodium chloride 0.9%, 500 mL, intravenous, AS NEEDED x1 dose for vein discomfort. Give concurrently with iron.

Standard included Nursing Orders:

- ✓ Vital signs. Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion and at the end of infusion.
- ✓ If hypersensitivity or infusion reactions develop, temporarily hold the infusion, and notify provider immediately.
- ✓ Include hypersensitivity reaction order set. (See attached form).



PROVIDENCE

Health & Services

ADULT AMBULATORY INFUSION ORDER

POIRONSUC-06/21

IRON SUCROSE (VENOFER) Infusion

NAME:
BIRTHDATE:
INSURANCE:
PROVIDER NAME:
CLINIC NAME and Phone number:

Patient identification

By signing below, I represent the following:

I am responsible for the care of the patient (*who is identified at the top of this form*).

I hold an active, unrestricted license to practice medicine in Oregon.

My physician license Number is # _____ [MUST BE COMPLETED TO BE A VALID PRESCRIPTION]; and I am acting within my scope of practice and authorized by law to order infusion of the medications and blood products described above for the patient identified on this form.

Provider's printed name: _____

Provider's signature: _____

Date: _____

Outpatient Infusion Services Intake Team:

Please check the appropriate box for the patient's preferred infusion center location:

Outpatient Infusion Services

- | | | |
|---|--------------------|------------------|
| <input type="checkbox"/> PORTLAND | Phone 503-215-6046 | Fax 503-487-3582 |
| <input type="checkbox"/> WILLAMETTE FALLS | Phone 503-215-6046 | Fax 503-487-3582 |
| <input type="checkbox"/> MEDFORD | Phone 541-732-7048 | Fax 541-732-3939 |
| <input type="checkbox"/> HOOD RIVER | Phone 541-387-1338 | Fax 541-387-6137 |
| <input type="checkbox"/> SEASIDE | Phone 503-717-7671 | Call for fax # |
| <input type="checkbox"/> NEWBERG | Phone 503-537-1450 | Fax 503-537-1449 |