

***IRON INFUSION CLINIC FORM***

**PATIENT INFORMATION**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Referral\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Height\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight (in KG)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BMI \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REFERRAL STATUS**

\_\_\_\_\_ New Referral \_\_\_\_\_ Dose or Frequency Change \_\_\_\_\_ Order Renewal

**DIAGNOSIS AND ICD-10 CODE**

\_\_\_ Iron Deficiency Anemia \_\_\_ Iron Deficiency due to blood loss Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ ICD 10 Code: D50.9 \_\_\_ ICD Code D50.0 ICD Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your patient unable to tolerate or had an inadequate response to oral iron supplements? \_\_\_\_ Yes \_\_\_\_ No

**MEDICATION ORDERS**

Please indicate dosing and frequency:

\_\_\_\_ Injectafer 750 mg IV Weekly for two doses \_\_\_\_ Injacetafer 750 mg IV #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Venofer 300 mg \_\_\_\_ Venofer (Other)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber Name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescriber Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_

**REQUIRED DOCUMENTATION**

* This signed order form by the provider
* Clinical/Progress notes supporting primary diagnosis
* Labs and tests supporting primary diagnosis (including CBC & I Iron Panel)
* Patient demographics and insurance
* Prior Authorization # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reference # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAX COMPLETED FORM AND ALL DOCUMENTATION TO:**

***Clay County Hospital Outpatient Infusion Clinic: Call 618-844-3062 Fax 618-844-3288***

***Infusion Orders – Injectafer (Ferric Carboxymaltose) – Venofer (Iron Sucrose)***

(Form 801.008)