Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Iron Deficiency Anemia ICD 10 Code: D50.9

☐ Iron Deficiency due to Blood Loss ICD 10 Code: D50.0

☐ Other: _____ ICD 10 Code: _____

Is your patient unable to tolerate, or had inadequate response to oral iron supplements? ☐ Yes ☐ No

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider

☐ Patient demographics AND insurance information

*Patient may be required to submit a pregnancy test prior to treatment

☐ Clinical/Progress notes (must be within 1 year)

☐ Labs and Tests supporting primary diagnosis

☐ CBC and Iron Panel

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt (in kg): BMI:

Dosing

Please indicate frequency in the blank space provided.

☐ J1756 Venofer 100mg IV every _____ (in 100mL NS, administered over 30 minutes)

☐ J1756 Venofer 200mg IV every _____ (in 100mL NS, administered over 30 minutes)

☐ J1756 Venofer 300mg IV every _____ (in 250mL NS, administered over 1.5 hours)

☐ J1756 Venofer _____ mg IV every _____

Patients will be monitored during infusion and for 30 minutes after, unless otherwise specified.

Duration ☐ _____ **doses; please note that cumulative doses >1000mg in a 14 day period are NOT recommended**

ADDITIONAL ORDERS / INFORMATION

PRESCRIBER INFORMATION

Prescriber name :		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Ph. 217-258-4150
Suite 204 Fax 217-348-2579
Mattoon, IL 61938

☐ EFFINGHAM
901 Medical Park Dr. Ph. 217-342-7500
Suite 201 Fax 217-342-7499
Effingham, IL 62401

INFUSION ORDERS - VENOFER (IRON SUCROSE)

Clinics Scan to: Physician Orders