



Outpatient Infusion Center  
Iron Order

Please fax form to: 580-585-5472

**Patient Information**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Gender: M F

Patient Address: \_\_\_\_\_ Email: \_\_\_\_\_ Insurance: \_\_\_\_\_

**Additional Information Needed**

Fax front/back of insurance card

Fax clinical/progress notes

Fax labs

Fax patient demographics

Fax current medication list

Fax TB and Hep B results

**Diagnosis and Clinical Information**

**Diagnosis (ICD-10):**

D50.0 Iron Deficiency Anemia Secondary to Blood Loss

D50.8 Other Iron Deficiency Anemias

D50.9 Iron Deficiency Anemia, Unspecified

D63.1 Anemia in Chronic Kidney Disease

Other: DX: \_\_\_\_\_

**Clinical Information:**

New Therapy Induction

Therapy Change

Therapy Continuation

Patient Weight: \_\_\_\_\_ lbs/ \_\_\_\_\_ kg

Patient Height: \_\_\_\_\_ in/ \_\_\_\_\_ cm

Allergies: \_\_\_\_\_

Therapies Tried and Failed: \_\_\_\_\_

TB Test: Date: \_\_\_\_\_ Results: \_\_\_\_\_ Hep B Test: Date: \_\_\_\_\_ Results: \_\_\_\_\_

Does the patient have non-dialysis dependent chronic kidney disease? Yes or No

Is the patient currently on dialysis? Yes or No Please indicate CKD Stage 1 2 3 4 5 Unknown

Does the patient have venous access? Yes or No

If yes, What type? \_\_\_\_\_

If No, initiate IV access.

**Lab Orders**

CBC w/o diff

Ferritin

Iron/IBC

Other: \_\_\_\_\_

**Lab Orders to be done by**

Infusion Services  
Referring Provider

**Prescription Information**

Injectafer

Dose: 15mg/kg (Patient weight <50kg)

Dose: 750mg (Patient weight >50kg)

Give 2 doses at least 7 days apart not to exceed 1500mg

Give 2 doses at least 7 days apart not to exceed 1500mg

Feraheme

Initial Dose: 510mg

Second Dose: 510mg 3 to 8 days after initial dose

Other

Medication: \_\_\_\_\_

Dose: \_\_\_\_\_

Frequency: \_\_\_\_\_

**Misc Orders**

PICC/Midline/CAD dressing to be changed every 7 days

**Flushes**

10mL NS Flush Syringe PRN

Heparin 500units/5mL Flush Syringe PRN

50mL NS Bag PRN

250mL NS Bag PRN

**Standing Orders for Adverse Reaction**

Stop infusion and initiate NS bolus

Notify Supervising physician and ordering provider

Solu-Cortef 100mg SIVP signs of adverse reaction

Benadryl 25 mg SIVP for hives or bronchial inflammation

Epi 1:1000 1mL IM, IV or SQ for anaphylaxis

Oxygen 2-5L nasal cannula

Albuterol 2.5mg inhaled PRN to chest tightness

Other: \_\_\_\_\_

**Prescriber Information**

Physician Name: \_\_\_\_\_ Official Contact Name: \_\_\_\_\_

Contact #: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

NPI#: \_\_\_\_\_ DEA#: \_\_\_\_\_ State License #: \_\_\_\_\_

Physician's Signature

Date

Time



PORD367

11/2021

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