Comanche County Memorial Hospital

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 patient demographics
- ☐ Fax clinical/progress notes
- ☐ Fax current medication list
- ☐ Fax labs
- ☐ 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	☐ Inital 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