SEMINOLE HOSPITAL DISTRICT
INFUSION CENTER
Phone: 432-758-4716 Fax: 877-249-1191

☐ **STAT REFERRAL**

IRON PRODUCT ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):_____

_____

Provider Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID #:_____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

_____Date of Diagnosis: _____

PERTINENT MEDICAL HISTORY

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

PRESCRIPTION ORDERS

a) ALL MEDIPORTS/IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE PER HOSPITAL PROTOCOL PRN UNLESS OTHERWISE NOTED BY PROVIDER
b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED PER STANDARD PHARMACY CONCENTRATIONS AND HOSPITAL POLICY
c) SUPPORTING LABWORK AND DOCUMENTATION OF ORAL IRON TREATMENT MAY BE REQUIRED BASED ON INDIVIDUAL PAYOR GUIDELINES
d) PRODUCT SUBSTITUTION MAY APPLY BASED ON AVAILABILITY OR INSURANCE REQUIREMENTS
e) PATIENTS TAKING FERAHEME MUST BE OBSERVED FOR 30 MINUTES POST INFUSION. BP AND PULSE MUST BE COLLECTED

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
	VENOFER	**mg**	**IV**		
	VENOFER	**200 mg**	**IV**	**ONCE EVERY WEEK**	**5 Doses**
	INJECTAFER	**750 mg**	**IV**	**ONCE EVERY WEEK**	**2 Doses**
	INJECTAFER ***(PATIENT WEIGHT > 50 kg)***	**15 mg / kg**	**IV**	**ONCE EVERY WEEK**	**2 Doses**
	FERRLECIT	**125 mg**	**IV**		
	FERRLECIT	**250 mg**	**IV**		
	FERAHEME	**510 mg**	**IV**	**ONCE, THEN REPEAT 3 – 8 DAYS LATER**	**2 Doses**
	OTHER:				

PREMEDS

SELECT BELOW	MEDICATION	DOSE	ROUTE
	NONE	**NA**	**NA**
	BENADRYL (diphenhydramine)	**50 mg**	**IV**
	TYLENOL (acetaminophen)		
	EPINEPHRINE	**0.3mg / 0.3ml**	**IM**
	SOLU-MEDROL (methylprednisolone)	**125 mg**	**IVP**
	Other:		
	OXYGEN:		

LABS

SELECT BELOW	LAB REQUESTED	WHEN	FREQUENCY
	NONE	**NA**	**NA**
	BMP	**( ) PRIOR ( ) POST**	
	CMP	**( ) PRIOR ( ) POST**	
	BUN/CREATININE	**( ) PRIOR ( ) POST**	
	H+H:	**( ) PRIOR ( ) POST**	
	Ferritin:	**( ) PRIOR ( ) POST**	
	Other:	**( ) PRIOR ( ) POST**	

NOTES:_____

Physician's Signature _____**Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Cosignature (If Required)_____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.