

LAWRENCE COUNTY
Memorial  Hospital
DEACONESS ILLINOIS PARTNER

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:
REFERRAL STATUS	
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal	
DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> Anemia due to Chronic Kidney Disease ICD 10 Code: D63.1 <input type="checkbox"/> Stage 1 <input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3a <input type="checkbox"/> Stage 3b <input type="checkbox"/> Stage 4 <input type="checkbox"/> Stage 5	
<input type="checkbox"/> Iron Deficiency Anemia ICD 10 Code: D50.9 <input type="checkbox"/> Other: _____ ICD 10 Code: _____	
<p>**If using D50.9 as primary code a secondary code is required</p> <p>**Is your patient unable to tolerate, or had inadequate response to oral iron supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)	
<input type="checkbox"/> The signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Prior authorization with reference number *Pt may be required to submit a pregnancy test prior to treatment	<input type="checkbox"/> Clinical/Progress notes (must be within 1 year) <input type="checkbox"/> Labs and test supporting primary diagnosis (must be within 1 year) <input type="checkbox"/> CBC and Iron Panel <input type="checkbox"/> Documented stage of CKD (cannot use CKD unspecified)
List of tried and failed therapies, including duration of treatment: 1) _____ 2) _____	
MEDICATION ORDERS	
Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____	
Dosing	<input type="checkbox"/> J1756 Venofer 100mg IV every _____ (in 100ml NS, administered over 30min) <input type="checkbox"/> J1756 Venofer 200mg IV every _____ (in 100ml NS, administered over 30min) <input type="checkbox"/> J1756 Venofer 300mg IV every _____ (in 250ml NS, administered over 1.5 hours) <input type="checkbox"/> J1756 Venofer ____ mg IV every _____ Patients will be monitored during infusion and for 30 minutes after, unless otherwise specified.
Duration: <input type="checkbox"/> x6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> x _____ doses (Cumulative doses >1000mg in a 14-day period are NOT recommended)	
PREMEDICATIONS/ LAB ORDERS	
<input type="checkbox"/> Acetaminophen _____ mg PO PRN <input type="checkbox"/> CBC <input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____ <input type="checkbox"/> Benadryl _____ mg PO or IV <input type="checkbox"/> CMP <input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____ <input type="checkbox"/> Methylprednisolone _____ slow IV push <input type="checkbox"/> Other: _____ Date: _____ <input type="checkbox"/> Other: _____	

ADDITIONAL ORDERS/INFORMATION

PRESCRIBER INFORMATION

Provider 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 PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515

FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS – VENOFER (IRON SUCROSE)