LAWRENCE COUNTY
Memorial Hospital
DEACONESS ILLINOIS PARTNER

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

DIAGNOSIS AND ICDE 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)

☐ The signed order form by the provider
☐ Patient demographics AND insurance information
☐ Prior authorization with reference number
*Pt may be required to submit a pregnancy test prior to treatment

☐ Clinical/Progress notes (must be within 1 year)
☐ Labs and test supporting primary diagnosis (must be within 1 year)
☐ CBC and Iron Panel

List of tried and failed therapies, including duration of treatment:
1) _____
2) _____

MEDICATION ORDERS

Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____ **Pt wt required for weight-based orders

Dosing	☐ J1439 Injectafer 75mg IV x2 doses at least 7 days apart ☐ J1439 Injectafer _____ It is recommended that doses are separated by 7 days. Patients will be monitored during infusion and for 30 minutes after, unless otherwise specified. In the event of any reactions, patient will be treated in the Emergency Department.

Duration: ☐ x6 months ☐ x 1 year ☐ x _____ doses

PREMEDICATIONS/ LAB ORDERS

☐ Acetaminophen _____mg PO PRN
☐ Benadryl _____mg PO or IV
☐ Methylprednisolone _____ slow IV push
☐ Other: _____

☐ CBC ☐ prior to each infusion or ☐ Frequency: _____
☐ CMP ☐ prior to each infusion or ☐ Frequency: _____
☐ Other: _____ Date:_____

ADDITIONAL ORDERS/INFORMATION

PRESCRIBER INFORMATION

Provider Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

ALL INFORMATION COUNTAINED 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 – INJECTAFER
(FERRIC CARBOXYMALTOSE)