

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 ICDE 10 CODE	
<input type="checkbox"/> Iron Deficiency Anemia <input type="checkbox"/> Iron Deficiency due to blood loss <input type="checkbox"/> Other: _____	ICD 10 Code: D50.9 ICD 10 Code: D50.0 ICD 10 Code: _____
Is your patient unable to tolerate, or had inadequate response to oral iron supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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
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	<input type="checkbox"/> Q0138 Feraheme 510mg IV x2 doses (3-8 days apart) <input type="checkbox"/> Q0138 Feraheme 510mg IV x _____ doses (3-8 days apart) 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: <input type="checkbox"/> x6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> x _____ doses	
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 – FERAHEME
(FERUMOXYOL)**