Center for Infusion Care
HILLSDALE HOSPITAL
Phone: (517) 212-4336 | **Fax:** (877) 249-1191
hillsdalehospital.com/infusion

☐ **STAT REFERRAL**

IRON PRODUCTS ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI____ DOB:_____

HT: _____ in WT: _____ kg Sex : ☐ Male ☐ Female Allergies: ☐ NKDA, _____

_____

Physician 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 OR HEPARIN PER HOSPITAL POLICY

b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED FOLLOWING HOSPITAL POLICY

c) SUPPORTING LABWORK AND DOCUMENTATION OF ORAL IRON TREATMENT MAY BE REQUIRED BASED ON INDIVIDUAL PAYOR GUIDELINES

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 Weeks
☐	FERRLECIT	125 mg	IV		
☐	FERRLECIT	250 mg	IV		
☐	FERAHEME	510 mg	IV	ONCE, THEN REPEAT 3 – 8 DAYS LATER	2 Doses
☐	OTHER:				

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE
☐	NONE	NA	NA
☐	BENADRYL	50 mg	IV
☐	ACETAMINOPHEN		
☐	OXYGEN		
☐	EPINEPHRINE	0.3mg / 0.3mL	IM
☐	SOLU-MEDROL	125 mg	IV
☐	Other:		

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.