Southwestern Medical Center
Empowered by ScionHealth
Phone: 580-531-4892
Fax: 877-249-1191

☐ **STAT REFERRAL**

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
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)

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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 PROTOCOL
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

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 BELOW	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.