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

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
VENOFER (IRON SUCROSE) ORDER FORM

☐ **STAT REFERRAL**

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 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

MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
VENOFER		**IV**	**Every_____ days**	

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.