

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			
INFUSION OFFICE PREFERENCES (Optional)			
Preferred Location* <input type="checkbox"/> Mattoon <input type="checkbox"/> Effingham <small>*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.</small>			
Diagnosis and ICD 10 CODE			
<input type="checkbox"/> Iron Deficiency Anemia		ICD 10 Code: D50.9	
<input type="checkbox"/> Iron Deficiency due to Blood Loss		ICD 10 Code: D50.0	
<input type="checkbox"/> Other: _____		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			
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> CBC and Iron Panel		<input type="checkbox"/> Clinical/Progress notes <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> Pregnancy Test (if applicable)	
MEDICATION ORDERS			
Dosing Wt for Calculations	Ht:	Wt: (in kg)	BMI:
Dosing <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <i>It is recommended that doses are separated by 7 days. Patients will be monitored during infusion and for 30 minutes after, unless otherwise specified. Our on-call provider will manage infusion related reactions, in the event that a reaction occurs.</i> </div>	<input type="checkbox"/> Injectafer 750mg IV weekly for 2 doses <input type="checkbox"/> Injectafer 750 mg IV _____		
Refills: <input type="checkbox"/> _____ doses			
ADDITIONAL ORDERS			
PRESCRIBER INFORMATION			
Prescriber name :			
Office Phone:		Office Fax:	
Prescriber Signature:		Date: _____ Time: _____	

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:

Fax Completed Form and all documentation to:

☐ MATTOON

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 Suite 204 Fax 217-348-2579
 Mattoon, IL 61938

☐ EFFINGHAM

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