

Iron Referral Form

**PATIENT INFORMATION**

**Referral Status:**

New Referral

Updated Order

Order Renewal

DOB:	Patient Name:	Patient Phone:	
Patient Address:		Patient Email:	
NKDA	Allergies:	Weight (lbs/kg):	Height:
ICD-10 code (required):	ICD-10 description:	Last Treatment Date:	Last 4 SSN:

**PROVIDER INFORMATION**

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

**NURSING**

Infusion to be administered per BioHealth protocols.

- Injectafer 750mg IV x2 doses separated by approximately 7 days
- Venofer 200mg IV x5 doses separated by approximately 2 to 7 days
- Venofer 300mg IV x3 doses separated by approximately 3 to 7 days (OB/GYN indications only)
- Feraheme 510mg IV x2 doses separated by approximately 3 to 8 days
- Monoferric 1,000mg IV once
- Other:

**LABORATORY ORDERS**

- CBC at each dose every \_\_\_\_\_
- CMP at each dose every \_\_\_\_\_
- CRP at each dose every \_\_\_\_\_
- OTHER \_\_\_\_\_

**PREMEDICATIONS**

- acetaminophen (Tylenol) 500mg 650mg 1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl) 25mg 50mg PO IV
- methylprednisolone (Solu-Medrol) 40mg 125mg IV
- hydrocortisone (Solu-Cortef) 100mg IV
- Other: \_\_\_\_\_
- Dose: \_\_\_\_\_ Route: \_\_\_\_\_
- Frequency: \_\_\_\_\_

**Required Documentation**

- Patient Demographics
- Insurance Card /Information
- Progress Notes Supporting DX
- Current Medication List and H&P

\*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. \*\*Order is valid for one year unless otherwise noted\*\*

Provider Name (Print)	Provider Signature	Date
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<p>Have a Question? (786)460-6044</p> <p>Fax Referral Form To: (786)219-3917</p> <p>8684 SUNSET DRIVE MIAMI FL 33143</p>
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