Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ _____ ICD 10 Code: _____

☐ _____ ICD 10 Code: _____

☐ _____ ICD 10 Code: _____

Is your patient unable to tolerate, or had inadequate response to oral iron supplements? ☐ YES ☐ NO

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider	☐ Clinical/Progress notes (must be within 1 year)
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis (must be within 1 year)
*Patient may be required to submit a pregnancy test prior to treatment	☐ CBC and Iron Panel

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt: (in kg) BMI:

Dosing	☐ J1439 Injectafer 750 mg IV _____ ☐ J1439 Injectafer _____
Sgl Dose Alternative	☐ J1439 Injectafer 15 mg/kg up to a maximum of 1000mg as a single dose per course
Pediatric Dosing Weight <50 kg	☐ J1439 Injectafer 15 mg/kg IV x2 doses separated by 7 days

Duration ☐ _____ **doses**

ADDITIONAL ORDERS /INFORMATION

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.

PRESCRIBER INFORMATION

Prescriber name :

Office Phone:	Office Fax:	Office Email:
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: SBL Infusion Center
Ph. 217-258-4150
217-342-7500

Fax Completed Form and all documentation to: Fax 217-342-7499

INFUSION ORDERS - INJECTAFER (FERRIC CARBOXYMALTOSE)

Clinics Scan to: Physician Orders