Injectafer Infusion Order

Fax 281-715-5302 Phone 281-265-0100

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:

◯ D50.9 Iron Deficiency Anemia, unspecified

◯ D50.8 Other iron deficiency anemias

◯ Other: _____

ICD-10 :_____

Patients weight: _____

Lab Date: _____

Allergies: _____

ALSO INCLUDE...

◯ Clinical/ Progress Notes

◯ Demographics Sheet

◯ Current Medications

◯ Labs

INJECTAFER ORDER

Patients Weight: _____ kg

Injectafer Dose:

◯ 15mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500mg - if patient weighing less than 50kg (110lbs)

◯ 750mg IV - Give 2 doses at least 7 days apart not to exceed 1500mg - if patient weighing 50kg (110lbs) or greater

Patient is currently taking Oral Iron ☐ YES ☐ NO

Date of last Injectafer Infusion: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____