Center for Infusion Care
HILLSDALE HOSPITAL
Phone: (517) 212-4336 | **Fax:** (877) 249-1191
hillsdalehospital.com/infusion

☐ **STAT REFERRAL**

IRON PRODUCTS ORDER FORM

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

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
	VENOFER	_____ mg	IV		
	VENOFER	200 mg	IV	ONCE EVERY WEEK	5 Doses
	INJECTAFER	750 mg	IV	ONCE EVERY WEEK	2 Weeks
	FERAHEME	510 mg	IV	ONCE, THEN REPEAT 3 – 8 DAYS LATER	2 Doses
	OTHER:				

PREMEDS

SELECT BELOW	MEDICATION	DOSE	ROUTE
	NONE	NA	NA
	BENADRYL	50mg	IV
	ACETAMINOPHEN		
	OXYGEN		
	EPINEPHRINE	0.3mg / 0.3ml	IM
	SOLU-MEDROL	125mg	IV
	Other:		

LABS

SELECT BELOW	LAB REQUESTED	WHEN	FREQUENCY
	NONE	NA	NA
	BMP	( ) PRIOR ( ) POST	
	CMP	( ) PRIOR ( ) POST	
	BUN/CREATININE	( ) PRIOR ( ) POST	
	CRP:	( ) PRIOR ( ) POST	
	ESR:	( ) 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.