


<b>Iron Deficiency Anemia Referral Form</b>	<b>Y Medical Associates</b> Fax: 855-838-0623 Phone: 800-447-7558	
Date: _____		

Patient Information	Prescriber Information
Patient Name: _____ Address: _____ City, State, Zip: _____ Home Phone: _____ Cell Phone: _____ DOB: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Prescriber Name: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ DEA: _____ NPI #: _____ Contact Person: _____

Insurance Information		
Primary Insurance: _____	ID#: _____	Group: _____
Secondary Insurance: _____	ID#: _____	Group: _____
Prescription Card: _____	ID#: _____	BIN#: _____ PCN#: _____ Group: _____

Medical Information	
Patient Weight: _____ Patient Height: _____ Allergies: _____	
<b>Diagnosis:</b> <input type="checkbox"/> D50.9 (Iron Deficiency Anemia) <input type="checkbox"/> D50.8 (Iron Deficiency Anemia Secondary to Inadequate Dietary Iron Intake) <input type="checkbox"/> Other _____	<b>Secondary ICD-10:</b> _____ <input type="checkbox"/> Adverse effect of other drug <i>(oral iron intolerance or not adequate)</i> <input type="checkbox"/> End-stage Renal Disease <input type="checkbox"/> Intestinal Malabsorption <input type="checkbox"/> Chronic Kidney Disease <input type="checkbox"/> Other medical necessity: _____
<input type="checkbox"/> Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached <input type="checkbox"/> Recent Labs: CBC, Ferritin, Iron Studies	
<b>Labs:</b> Required labs to be drawn by: <input type="checkbox"/> Infusion Clinic <input type="checkbox"/> Referring Physician	
<b>Lab Orders:</b> _____	

Medications		
DRUG	DOSE/STRENGTH	DIRECTIONS
Infed	<input type="checkbox"/> 50mg/mL	<input type="checkbox"/> Infuse _____ mL over _____
Injectafer	<input type="checkbox"/> 15mg/kg (<50kg) IV <input type="checkbox"/> 750mg (>/=50kg) IV	<input type="checkbox"/> _____
Monoferric	<input type="checkbox"/> 20mg/kg (<50kg) <input type="checkbox"/> 1000mg (>/=50kg)	<input type="checkbox"/> One time dose IV <input type="checkbox"/> Other: _____
Venofer	<input type="checkbox"/> 200mg <input type="checkbox"/> 100mg	<input type="checkbox"/> Infuse 200mg IV weekly x 5 doses <input type="checkbox"/> Infuse 200mg IV 5 doses over a 14 day period

<b>Anaphylaxis Orders and Medications</b> Diphenhydramine Administer 25 mg slow IV/IM may repeat x1 <b>Dispense:</b> 1 x 50 mg vial Epinephrine Autoinjector <input type="checkbox"/> Administer 0.15mg (1:2000) IM (< 30 Kg) <input type="checkbox"/> Administer 0.3mg (1:1000) IM (≥ 30 Kg) <b>Dispense:</b> 1 package (2 pens) Sodium Chloride 0.9% <i>Use to maintain IV line, prevent or treat hypotension in case of anaphylaxis</i> <b>Dispense:</b> QS	<b>IV Access Flush Order</b> NaCl 0.9% 5-10ml IV before and after infusion Heparin 10 Units/ml 5ml after infusion for PICC/Midline Heparin 10 Units/ml 3ml after infusion for PIV Heparin 100 Units/ml 5ml IV after infusion for PORT All infusion supplies necessary to administer the medication
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Prescriber Signature: _____	DAW (Dispense as Written) Date: _____
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