Iron Deficiency Anemia Referral Form	Y Medical Associates Fax: 855-838-0623 Phone: 800-447-7558	YMedical ASSOCIATES
Date: _____		

Patient Information

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
DOB: _____
Gender: ☐M ☐F

Prescriber Information

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: _____

Diagnosis:

☐ D50.9 (Iron Deficiency Anemia)
☐ D50.8 (Iron Deficiency Anemia Secondary to Inadequate Dietary Iron Intake)
☐ Other _____

Secondary ICD-10: _____

☐Adverse effect of other drug
(oral iron intolerance or not adequate)
☐ End-stage Renal Disease
☐ Intestinal Malabsorption
☐Chronic Kidney Disease
☐ Other medical necessity: _____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached
☐ Recent Labs: CBC, Ferritin, Iron Studies

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

Medications

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

Anaphylaxis Orders and Medications

Diphenhydramine Administer 25 mg slow IV/IM may repeat x1
***Dispense**: 1 x 50 mg vial*

Epinephrine Autoinjector ☐ Administer 0.15mg (1:2000) IM (< 30 Kg)
☐ Administer 0.3mg (1:1000) IM (≥ 30 Kg)
Dispense: 1 package (2 pens)
Sodium Chloride 0.9% *Use to maintain IV line, prevent or treat hypotension in case of anaphylaxis*
***Dispense**: QS*

IV Access Flush Order

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

Prescriber Signature: _____ **DAW (Dispense as Written) Date:** _____