INFUSION ORDERS- VENOFER (IRON SUCROSE)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS		
☐ New Referral	☐ Dose or Frequency Change	☐ Order Renewal

Other:

DIAGNOSIS AND ICD 10 CODE	
☐ Iron Deficiency Anemia	ICD 10 Code: D50.9
☐ Iron Deficiency due to Blood Loss	ICD10 Code: D50.0
☐ Other: ____	ICD10 Code: _____________________
Is your patient unable to tolerate, or had inadequate response to oral iron supplements?	☐ YES ☐ NO

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ CBC and Iron Panel	

MEDICATION ORDERS	
Dosing	Please indicate frequency in the blank space provided. ☐ Venofer 100mg IV every _______________ (in 100mL NS, administered over 30 minutes) ☐ Venofer 200mg IV every _______________ (in 100mL NS, administered over 30 minutes) ☐ Venofer 300mg IV every _________________ (in 250mL NS, administered over 1.5 hours) ☐ Venofer _______ mg IV every ______________ Patients will be monitored during infusion and for 30 minutes after, unless otherwise specified. Nurse to start PIV per protocol , remove upon completion of infusion. Follow standing anaphylaxis order.
Refills: ☐	_____ doses ; please note that cumulative doses >1000mg in a 14 day period are NOT recommended

PHYSICIAN INFORMATION		
Prescribing Physician:		
Office Phone:	Office Fax:	Office Email:
Physician Signature:		Date:

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: 281-406-1046
Fax Completed Form and all documentation to: 281-406-1047