Intravene – Injectafer Infusion Orders (rev 7/2020)

FAX to 434-455-5531 along with copy of insurance cards
Or CALL 434-947-3900 Ext. 2172

PATIENT INFORMATION

Name: ______________________
Address: ______________________
City: ______________________
State: __________ Zip Code: __________
Home Phone #: ______________________
Work Phone #: ______________________
DOB: __________ SSN: __________
Height : ________ Weight: ________ Sex: ______
Allergies: ______________________

REFERRING PHYSICIAN INFORMATION

Physician Name: ______________________
Physician Address: ______________________
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Physician Phone: ______________________
Physician Fax: ______________________
NPI#: __________ DEA#: __________
State License#: ______________________

****Please fax copy of insurance cards and this** form to 434-455-5531**

DIAGNOSIS: **(ICD-10 required)**

- ☐ ______________________ ______________________
- ☐ ______________________ ______________________
- ☐ ______________________ ______________________

STANDARD ORDERS:

Infuse Injectafer __________mg in Normal Saline 250ml via infusion pump over 30 minutes. Infuse 2 doses at least 7 days apart. Upon completion of Injectafer infusion, infuse Normal Saline 20ml to clear line. Observe patient for 30 minutes after infusion complete.

DOSING TABIE:

Body Weight	Dose
<50 kg (<110 lbs)	15mg/kg
>50 kg (>110 lbs)	750mg

Anaphylactic meds and Vital Sign Monitoring per Intravene Protocol

May discharge from Intravene services after infusions completed

SIGNATURE, PRESCRIBING MD: ______________________ **DATE:** __________