Intravene – Venofer Infusion Orders (rev 9/2021)

FAX to 434-455-5531 along with copy of insurance cards
Or CALL 434-947-3900 Ext. 3001

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:_____
_____
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)**

- ☐ _____ _____
- ☐ _____ _____
- ☐ _____ _____

Please note Medicare Patients must have diagnosis of Anemia AND End stage renal disease

STANDARD ORDERS:

Infuse Venofer _____mg in Normal Saline 100ml to 250ml via infusion pump over 1-4 hours (based on dose) Infuse weekly for _____doses.
Upon completion of Venofer infusion, infuse Normal Saline 20ml to clear line. .

PREMEDICATIONS: _____
_____

Anaphylactic meds and Vital Sign Monitoring per Intravene Protocol

May discharge from Intravene services after infusions completed

SIGNATURE, PRESCRIBING MD:_____DATE:_____