



Phone: (833) 394-0600 Fax: (833) 996-4888

Venofer Infusion

Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications and Recent Visit Notes

Referral status: NEW referral Dose or frequency change Order renewal

Date: ____/____/____

Patient Name: _____ DOB: ____/____/____

Allergies: _____ Patient Weight: _____ lbs/kg Height: _____

ICD-10: _____, _____, _____

Is this referral **URGENT** (to be administered within 5-7 days) rationale: _____

Does patient have chronic kidney disease? No Yes, what stage and ICD10 code? _____

Hemoglobin: _____ Date collected: _____

Ferritin: _____ Date collected: _____

Is patient on hemodialysis: Yes No

Is patient currently on an erythropoietin product ? Yes No

Is patient unable to tolerate, or had inadequate response to oral iron supplements? Yes No

Labs:
 Pharmacist to order labs per protocol
Labs to be drawn _____ weeks after infusion course is complete:
 CBC Iron Studies (Iron, T-sat, TIBC, Ferritin) Other: _____

Pharmacist to dose Venofer

Venofer (Iron Sucrose) IV

Dose: 100 mg 200mg 300mg 400mg

Frequency: Every OTHER day 2-3 doses a week Weekly _____

Number of doses: _____

Printed Provider Name: _____

Provider Signature: _____

Office Phone Number: _____ Office Fax Number: _____

Contact Name: _____ Contact Phone Number: _____

New referring providers, how did you hear about us? Web Search Pharma Rep Drug Locator Patient
 Word of Mouth IA Clinical Liaison IA Website Facebook Instagram TV/streaming Other: _____