Infusion ASSOCIATES

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: _____

## ☐ Infusion Associates provider 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: _____