Iron Infusion Order

Provider Order Form Rev. 7.2025

Please fax completed referral form & all required documents to 208-595-4427

INFUSED HEALTH
MEDICAL • KETAMINE • HYDRATION
IV THERAPY

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/State/Zip: _____

Weeks Gestation: _____ Allergies: _____ ☐ NKDA Weight: _____☐lbs☐kg Height: _____☐in☐cm

DIAGNOSIS

*ICD 10 Code Required

☐ Iron deficiency without anemia, ICD10—E61.1

☐ Iron deficiency anemia, unspecified, IDC10—D50.9

☐ Anemia complicating pregnancy, IDC10—O99.01

☐ _____, IDC10 _____

INFUSION ORDERS

☐ Infed (Iron Dextran): 1000 mg in 250 mL NS to infuse over 45 minutes. (Perform 25 mg test dose over five minutes, observe patient for 1 hour for ADR.)

☐ Venofer (Iron Sucrose): 200 mg slow IV push over 2-5 minutes x5 doses over a 14 day period.

☐ Other: _____

Is patient currently receiving therapy above from another facility? ☐NO☐YES
If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/State/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

LABS and TEST RESULTS (required)

HGB_____ Date: _____

Ferritin_____ Date: _____

TSAT_____ Date: _____

Does patient have chronic kidney disease? ☐ Yes☐No

If yes, what stage and ICD10 code? _____

Is patient on hemodialysis? ☐ Yes☐No

Is patient currently on an erythropoietin product? ☐Yes ☐No