

Richmond
7110 Forest Ave, Suite 203
Richmond, VA 23226



Prince George
2025 Waterside Rd, Suite 100B
Prince George, VA 23875

Physician Order - Venofer (iron sucrose)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:
Patient Weight: _____ kg _____ lb	Patient Height: _____ in

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose/Frequency Change <input type="checkbox"/> Order Renewal

Location Preference (optional)
<input type="checkbox"/> Richmond <input type="checkbox"/> Prince George

** If the patient has a central line - we need official placement report, diagnostic imaging to confirm tip placement and date of last access **

DIAGNOSIS AND ICD-10 CODE
<input type="checkbox"/> Iron Deficiency Anemia D50.9
<input type="checkbox"/> Iron Deficiency Anemia due to blood loss D50.0
<input type="checkbox"/> Other: _____ ICD10 _____
Is your patient unable to tolerate, or had inadequate response to oral iron supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No

REQUIRED DOCUMENTATION (must include)
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Clinical/Progress Notes
<input type="checkbox"/> Patient Demographics AND Insurance Information <input type="checkbox"/> Labs and Tests Supporting Primary Dx
<input type="checkbox"/> CBC results, within 14 days <input type="checkbox"/> Ferritin OR Iron Saturation results, within 14 days
Is your patient unable to tolerate, or had inadequate response to oral iron supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICATION ORDERS
<input type="checkbox"/> Venofer 100mg infuse IV over 30 minutes 3 times weekly x _____ doses
<input type="checkbox"/> Venofer 200mg infuse IV over 30 minutes 3 times weekly x _____ doses*
<input type="checkbox"/> Venofer _____mg (<i>max 300mg per dose</i>) infuse IV over 30 minutes _____ weekly x _____ doses*
<i>* MAXIMUM is 1000mg per 14 days</i>

OPTIONAL PREMEDICATIONS and LAB ORDERS
<input type="checkbox"/> Acetaminophen 650mg PO prior to infusion
<input type="checkbox"/> Diphenhydramine 25mg PO or IV (per patient preference) prior to infusion
<input type="checkbox"/> Methylprednisolone 40mg slow IVP prior to infusion
<input type="checkbox"/> Other PreMed and Lab Order with frequency: _____

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION		
Prescriber Name:	NPI:	Contact:
Phone:	Fax:	Email:
Prescriber Signature:	Date:	

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com

Fax completed form and ALL required documentation to 804-554-5848

All information contained in this form is strictly confidential and will become part of the patient's record.