



# Iron Order Form

Select patient referral location:  Akron  Blue Ash  Cleveland  Columbus  Crestview Hills  Springfield  West Cincinnati  
 Other \_\_\_\_\_

Fax completed form to 888-977-0914. For new referrals, please **include recent labs and last two office visit notes.**

Toll Free Phone: 877-787-8720 • www.horizoninfusions.com

## 1. PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> Lbs <input type="checkbox"/> Kg
Patient Status: <input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy <input type="checkbox"/> Next due date (if applicable):	

## 2. PHYSICIAN INFORMATION

Physician's name:	NPI#:
License #: _____ TIN#: _____	DEA#:
Address:	
City:	State: _____ Zip: _____
Office contact:	Email:
Office phone:	Office fax:

## 3. DIAGNOSIS INFORMATION (and year of diagnosis)

Iron Deficiency Anemia  ICD 10 ( \_\_\_\_\_ )  Other (specify): \_\_\_\_\_

## 4. INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

## 5. PRESCRIPTION INFORMATION (requires new order every 12 months)

<p><b>IRON</b></p> <p>MONOFERRIC</p> <p><input type="checkbox"/> Over 50 kg: 1000 mg over at least 20 minutes</p> <p><input type="checkbox"/> Under 50 kg: 20 mg/kg over at least 20 minutes</p> <p>INJECTAFER</p> <p><input type="checkbox"/> Over 50 kgs: Administer 2 doses of 750 mg at least 7 days apart for a total dose of 1500 mg IV</p> <p><input type="checkbox"/> Under 50 kgs: Administer 2 doses at least seven days apart; each dose 15 mg/kg IV</p> <p><input type="checkbox"/> Vital signs per HI Protocol</p> <p><input type="checkbox"/> Anaphylaxis &amp; Hydration Management per HI Protocol</p>	<p><b>PRE-MEDICATIONS</b> <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg PO</p> <p><input type="checkbox"/> Fexofenadine (Allegra) 180mg PO (or other non-sedating anti-histamine)</p> <p><input type="checkbox"/> Diphenhydramine (Benadryl) <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> PO <input type="checkbox"/> IV (requires driver)</p> <p><input type="checkbox"/> Methylprednisolone (Solu-Medrol) <input type="checkbox"/> 40mg <input type="checkbox"/> 80mg <input type="checkbox"/> 125mg IV</p> <p><input type="checkbox"/> Prednisone _____ mg PO</p> <p><input type="checkbox"/> Other: _____</p> <p><b>POST-MEDICATIONS</b> <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg PO</p> <p><input type="checkbox"/> Prednisone _____ mg PO</p> <p><input type="checkbox"/> Other: _____</p>
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## 6. LABS

<input type="checkbox"/> CBC w/Diff	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> CRP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> CMP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> ESR	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Hepatic Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Renal Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Quantiferon TB Gold, annually, last completed (date): _____		
<input type="checkbox"/> Other (specify): _____		

## 7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_