Horizon Infusions

Iron Order Form

Select referral location:

Akron	Columbus (East Broad)	Findlay	Toledo
Athens	Columbus (Hilliard)	Liberty	Crestview Hills (NKY)
Cincinnati (Blue Ash)	Columbus (Worthington)	Mansfield	
Cincinnati (West)	Dayton (Beavercreek)	Perrysburg	
Cleveland	Dayton (Englewood)	Springfield	

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to 888-977-0914
Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name: _____ DOB: _____
Phone: _____ Other Phone: _____
Email: _____
Social Security #: _____ Allergies: _____
Gender: M   F   Weight: _____ Lbs   Kg
Patient Status: New to therapy   Continuing therapy   Next due date (if applicable): _____

2. INSURANCE INFORMATION (required)
Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name: _____ NPI#: _____
License #: _____ TIN#: _____ DEA#: _____
Address: _____
City: _____ State: _____ Zip _____
Office Contact: _____ Email: _____
Office phone: _____ Office fax: _____

4. DIAGNOSIS INFORMATION (and year of diagnosis)

Iron Deficiency Anemia (_____)   ICD 10 (_____)   Other: _____

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

MONOFERRIC
Over 50kg: 1000mg over at least 20 minutes

Under 50kg: 20mg/kg over at least 20 minutes

INJECTAFER
Over 50kg: Administer two doses of 750mg at least 7 days apart for a total dose of 1500mg IV

Under 50kg: Administer two doses at least 7 days apart; each dose 15mg/kg IV

Vital signs per HI Protocol
Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS   N/A
Acetaminophen   500mg   650mg   1000mg
Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
Diphenhydrimine (Benadryl)   25mg   50mg   PO   IV (requires driver)
Methylprednisolone (Solu-Medrol)   40mg   80mg   125mg IV
Prednisone _____ mg PO
Other _____

POST-MEDICATIONS   N/A
Acetaminophen   500mg   650mg   1000mg
Prednisone _____ mg PO
Other _____

6. LABS

CBC w/Diff	Each Infusion	Other Frequency (specify): _____
CRP	Each Infusion	Other Frequency (specify): _____
CMP	Each Infusion	Other Frequency (specify): _____
ESR	Each Infusion	Other Frequency (specify): _____
Hepatic Panel	Each Infusion	Other Frequency (specify): _____
Renal Panel	Each Infusion	Other Frequency (specify): _____

Quantiferon TB Gold, annually, last completed (date): _____
Other (specify): _____

7. SIGNATURE (required)

_____   _____
PHYSICIAN'S SIGNATURE   **DATE**