Phone: (865) 862 - 4557
www.heartlandinfusion.com
Fax: (865) 862 – 4556
Alt. Fax: (865) 867 - 7081

Injectafer Order Form

Please fax completed form with patient demographic information, front and back of insurance card (s), recent lab results, and recent office visit notes supporting diagnosis to (865) 862-4556.

Referral Status: ☐ New referral ☐ Dose or frequency change ☐ Order Renewal

PATIENT INFORMATION

Name:

Home Phone: Cell Phone:

Email: Last four Social Security number

DOB: Height: Weight:

Allergies:

ICD-10 Diagnosis Code: Years with Disease:

TB Test (Circle One): Skin Quantiferon Chest Xray Result: Date:

LABORATORY ORDERS

☐ CBC w/ Diff	☐ each infusion	☐ Other ________
☐ CRP	☐ each infusion	☐ Other ________
☐ CMP	☐ each infusion	☐ Other ________
☐ ESR	☐ each infusion	☐ Other ________
☐ Hepatic Panel	☐ each infusion	☐ Other ________
☐ Renal Panel	☐ each infusion	☐ Other ________
☐ Quantiferon TB (annually)		Due: ________
☐ Other		

Therapy Orders

☐ Under 50 kgs: Administer 15mg/kg Injectafer (ferric carboxymaltose) IV per dose, times 2 doses, at least 7 days apart

☐ Over 50 kgs: Administer 750mg Injectafer (ferric carboxymaltose) IV per dose, times 2 doses, at least 7 days apart; total dose 1500mg.

☐ Nursing per Heartland Nursing Procedures (incl reaction management)

☐ **Pre-Medications** ☐ No routine pre-medications required

☐ Tylenol (acetaminophen) ________ mg PO ☐ Zyrtec (cetirizine) 10 mg PO

☐ Solu-Medrol (methylprednisolone) ________mg IV ☐ Claritin (loratadine) 10 mg PO

☐ Benadryl (diphenhydramine) ________mg ☐ PO ☐ IV

☐ Other: ________________________________

PHYSICIAN INFORMATION

Physician's Name:

License #: NPI#: DEA#:

Address:

City: State: Zip:

Office Contact: Email:

Office Phone: Office Fax:

Physician Signature: ________________________________ Date: ____________

Patient is being referred to: ☐ Knoxville ☐ Morristown ☐ Kingsport