RECOVERY ROOM IV THERAPY, LLP.

Phone: 480-865-3322 Fax: 480-866-8189

Injectafer Referral Order Form

Patient Information

Patient Name:	Patient DOB:
Patient Phone #:	Sex of Patient:

Provider Information

Ordering Provider Name:	NPI # of Prescribing Provider:
Office Contact Name:	Office Phone #:
Office Contact Fax #:	Office Contact Email:

Injectafer Medication Orders

Dosage

- **Patients greater than or equal to 50kg**: ____Two dose regimen – 750mg IV once then a second dose of 750mg once at least 7 days after the first dose or ____ Single dose regimen – 15mg/kg IV once
- **Patients less than 50kg:** ____ 15mg/kg IV once then then a second dose of 15mg/kg once at least 7 days after the first dose
- _____ Other _____

Patient Weight: _____ Lbs or _____ Kg

Diagnosis with ICD 10 code **(REQUIRED)**

- Diagnosis: _____ Iron deficiency anemia ____ Other _____
- ICD 10 code _____

Pre-Medication	Refills
• Tylenol _____mg • Benadryl _____ mg __IV or ___PO • Solumedrol IV Push _____ mg • Other _____	• Zero _____ • Treatments for 1 year _____ • Other _____

Required Documentation

○ **Insurance Cards (Front and Back)**	○ **Patient Demographics** ○ **Lab Results – CMP, CBC**	○ **Recent Progress Notes**

Special Instructions/Notes

_____ _____

Prescribing Provider Signature **Date of Signature**