

**Patient Information**

Patient Name:		DOB:	
Patient Home Phone:	Patient Cell Phone:	Patient Email:	
Emergency/Alternate Contact Name:		Emergency/Alternate Contact Phone:	
NKDA	Allergies:	Weight lbs/kg:	Height:
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change
Last infusion date (if applicable):		_____	
Is the patient pregnant, planning a pregnancy or nursing:		Yes	No
Does the patient need interpreter services:		Yes	No

**Provider Information**

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip:

**ICD-10 CODE**

D64.9 Anemia unspecified (includes Anemia due to medications)  
 D63.1 Anemia in chronic kidney disease (select secondary code to indicate type of CKD)  
     N18.30 CKD, stage 3 unspecified      N18.5 CKD, stage 5  
     N18.4 CKD, stage 4                      N18.6 End stage renal disease  
 Other: \_\_\_\_\_

**Medication Order**

<b>Feraheme</b> (ferumoxytol)	Dose: 510mg IV	Frequency: One dose followed by a second dose 3 to 8 days later	Other: _____
<b>Infed</b> (iron dextran)	Dose: 1,000mg IV Other: _____	Frequency: Once	Other: _____
<b>Monoferric</b> (ferric derisomaltose)	Dose: 1,000mg IV      20mg/kg IV Other: _____	Frequency: Once	Other: _____

**Documentation Required (Note: Send all labs, must include specific labs listed here)**

Labs (Iron)	Insurance Card (front and back)	Current Medications	History/Progress Notes
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**Pre-Medication Order**

<b>acetaminophen</b> (Tylenol)	500mg      650mg      1000mg PO	<b>diphenhydramine</b> (Benadryl)	25mg      50mg /	PO      IV
<b>cetirizine</b> (Zyrtec)	10mg PO	<b>methylprednisolone</b> (Solu-Medrol)	40mg IV      125mg IV	
<b>loratadine</b> (Claritin)	10mg PO	<b>hydrocortisone</b> (Solu-Cortef)	100mg IV	
Other: _____				
Dose: _____		Route: _____		Frequency: _____

**Special Instructions (Prior therapy, treatment dates, and reasons for d/c)**

**Provider Name**

**Provider Signature**

**Date**

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

Check here if this is a stat order

**Patient Information**

Patient Name:	DOB:	Sex:	M	F	Fasting:	Y	N
Patient Home Phone:	Patient Cell Phone:						
Emergency/Alternate Contact Name:	Emergency/Alternate Contact Phone:						

**Lab Test (Please circle or write in ICD-10)**

ALT	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgE	J45.4, J45.3, L50.9, J45.40, J45.50
AST	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgG	G35, G36.0
HEPATIC FUNCTION PANEL	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IMMUNOGLOBULIN QUANT IgG, IgM, IgA	G35, G36.0
BASIC METABOLIC PANEL	I10, E87.1, Z79.899, E87.5, E80.20, G35, M81.0, M81.8, N18.9	IMMUNOGLOBULIN QUANT IgG, IgM, IgA, IgE	G35, G36.0
CALCIUM	M81.0, M81.8	IRON, TIBC, FER PNL	D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
CBC (INCLUDES DIFF/PLT)	I10, D64.9, Z00.00, R53.83, G35, C50.011, D70.9, D50.0, D63.1	LIPID PANEL	Z79.899, E78.5, E55.9, E78.00, Z00.00, E78.01, E78.2
CBC (H/H, RBC, WBC, PLT)s	I10, Z00.00, Z13.0, D64.9, G35, C50.011, D70.9, D50.0, D63.1	MAGNESIUM	I10, Z79.899, R25.2, E83.42, Z00.00
COMP METABOLIC PANEL	I10, Z79.899, E78.5, E11.9, E78.2, E80.20, G35, M81.0, M81.8, N18.9	PSA	R97.20, C61, N40.1, Z12.5, N40.0
CREATININE	M81.0, M81.8, G35	PROTHROMBIN TIME-INR	Z79.01, I48.91, I48.0, Z51.81
C-REACTIVE PROTEIN (CRP)	R53.83, R79.82, M35.3, I10, M06.9, K50.90, K51.90, M32.9, L40.50	TRANSFERRIN SATURATION	D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
FERRITIN	D64.9, D50.9, D50.0, D50.8, Z00.00, D63.1, N18.9	QUANTIFERON TB GOLD	Z79.899, Z00.00, Z01.84, M06.9, M08.9, M45.0, L40.0, L40.50, K51.90, K50.90
G6PD	M1A.9XX0, M1A.9XX1	TSH	E03.9, I10, E03.8, R53.83, E06.3, E05.00
GROWTH HORMONE	E22, C7A.1, E34	URIC ACID	M10.9, E79.0, I10, Z00.00, M1A.9XX0, M1A.9XX1
HEMOGLOBIN & HEMATOCRIT	D50.9, D64.9, D50.0, D63.1, N18.9	VIT B12/FOLIC ACID	M89.49, E53.8, R53.83, F41.8, F41.9, E05.00
HEMOGLOBIN A1C	E11.9, E11.65, R73.01, Z00.00, I10	VIT D 25- HYDROX	E55.9, Z00.00, R53.83, I10, Z79.899, M81.0, M81.8
HEP B SURF AG	Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0	Miscellaneous Labs Not Listed (Write In)	

**Frequency**

Prior to each dose      Yearly      Other: Please Specify Below

Lab Test: \_\_\_\_\_ Frequency: \_\_\_\_\_

Lab Test: \_\_\_\_\_ Frequency: \_\_\_\_\_

Lab Test: \_\_\_\_\_ Frequency: \_\_\_\_\_

Lab Test: \_\_\_\_\_ Frequency: \_\_\_\_\_

 \_\_\_\_\_  
**Provider Name**

 \_\_\_\_\_  
**Provider Signature**

 \_\_\_\_\_  
**Date**

 \_\_\_\_\_  
**Provider Phone**