Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: _____ Patient D.O.B._____

Current Height: _____ Current Weight_____

Patient Phone # (_____) _____-_____ Gender_____

Patient Address _____

City_____ State _____ Zip Code_____

Related Diagnosis Code (ICD-10 code): _____

Referring Provider (Please Print) _____

Office Phone # (_____) _____-_____ Office Contact: _____

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

IV Iron Treatment Plan

Patient Name: _____ **Patient DOB** _____

General

Diagnosis-_____ ICD-10 Code _____

Pt. Weight _____ Pt Height _____ Known Allergies _____

Requested Start Date ____/____/_____

Has patient previously received this medication ☐ No ☐ Yes, if so, date of last infusion ____/____/_____

** **Referring provider should attach hemoglobin and hematocrit results (minimum) in addition to any additional iron studies available for use in the insurance authorization process. H&H must have been obtained within the last 30 days.**

Indication for treatment:

☐ Oral iron ineffective ☐ Oral iron not tolerated ☐ Chronic kidney disease ☐ Oral iron drug interaction

Infusion (Month 1 to 12) Duration: 12 Months

☑ Vital Signs (Month 1 to 12)
every 30 min, Resp, BP, HR, Temperature on admission to the unit and prior to infusion HR, BP every 30 minutes during the infusion and prior to discharge

☑ Vital Signs (Month 1 to 12)
as needed if patient experiences adverse reaction until one hour after symptom resolution

Pre- Treatment Medications

Tylenol (Month 1 to 12)
☐ *650 mg, Oral, Tab, Day of Tx*
Comments: Administer 30 minutes before iron infusion

Benadryl (Month 1 to 12)
☐ *25 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before iron infusion
☐ *50 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before iron infusion

SOLU-Medrol (Month 1 to 12)
☐ *40 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before iron infusion
☐ *125 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before iron infusion

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____

IV Iron Treatment Plan

☐ **Iron Sucrose (Venofer®)**

☐ *200 mg, IV Piggyback, Injection, Day of Tx followed by _____ additional dose(s) {Max=4}*
Comments: In 100 mL NS over 30 minutes. Maximum dose is 1000mg in 5 divided doses over a 14 day period. Observe patients for at least 30 minutes post infusion

☐ **Ferric Carboxymaltose (Injectafer®)**

☐ *750 mg, IV Piggyback, Soln-IV, Day of Tx **[Greater Than or Equal To 50 kg]*** followed by **__1__** additional dose(s) given 7 days apart
Comments: administer as an IV infusion, dilute up to 750 mg in a maximum of 250 mL of 0.9% sodium chloride injection to a concentration of 2-4 mg/mL; concentration should be =2 mg/mL

☐ *15 mg/kg, IV Piggyback, Soln-IV, Once **[Less Than 50 kg]** followed by **__1__** additional dose(s) given 7 days apart*
Comments: administer as an IV infusion, dilute in a maximum of 250 mL of 0.9% sodium chloride injection to a concentration of 2-4 mg/mL; concentration should be =2 mg/mL

☐ **Ferumoxytol (Feraheme®)**

☐ *510 mg, IV Piggyback, Injection, Day of Tx with a second dose to be given 3-8 days later*
Comments: Mix in 100 mL NS, infuse over 30 minutes. Infuse at no greater than 1 mL/sec.

☑ Communication Order (Month 1 to 12)
Patient must stay in infusion area for 30 min post infusion. If vital signs normal may be discharged to home. If abnormal, call physician.

☑ Notify Provider (Month 1 to 12)
for fever/chills, chest pain, hypotension, hypertension, dyspnea, Pruritis, urticaria, persistent flushing Temperature > 100 or HR <50 or > 130

☑ INF Infusion Room Orders Subphase (Month 1 to 12)

☐ heparin flush 100 units/mL intravenous solution (Month 1 to 12)
5 mL, Intracatheter, Injection, Once, PRN other (see comment)
Comments: To maintain central line patency for implanted ports, flush once monthly or prior to deaccess

Labs:

Ordering provider acknowledges responsibility for laboratory monitoring including but not limited to CBC, Ferritin, and Iron studies as clinically appropriate. Note: Iron studies are not recommended to be completed sooner than 30 days following the completion of the iron infusions.

Provider Initials: _____

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____