Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: ________________________________ Patient D.O.B.___________________________

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** ____________________________

☐ Diagnosis-__Iron Deficiency Anemia ____ ICD-10 Code ___D50.9___

☐ Other 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

Dexamethasone (Month 1 to 12)

☐ *10 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_____/_____/__________

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 [Day 0,3,5,8, and 11***]*. Observe patients for at least 30 minutes post infusion (Days may be adjusted to accommodate availability)*

☐ *200 mg, IV Piggyback, Injection, Day of Tx followed by __________ additional dose(s) {Max=4}*
Comments: In 100 mL NS over 30 minutes. ***Doses to be administered every 7 days (weekly***) *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 _____ additional dose(s) given 7 days apart {Max 1 additional dose}
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 ____ additional dose(s) given 7 days apart* {Max 1 additional dose}
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 7 days later***
Comments: Mix in 100 mL NS, infuse over 30 minutes. Infuse at no greater than 1 mL/sec.

☐ *510 mg, IV Piggyback, Injection,* ***x1 dose***
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 > 100F or HR <50 or > 130

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

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________________