IRON DEFICIENCY ANEMIA

FLOURISH™ HEALTH GROUP

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • H&P • Patient Demographics • Medication List • Recent Iron Panel / H&H
• Intolerance or unsatisfactory response to oral Iron supplementation

PRIMARY DIAGNOSIS

☐ D50.0 Iron deficiency anemia secondary to blood loss (chronic)
☐ D50.8 Other iron deficiency anemias
☐ D50.9 Iron deficiency anemia, unspecified
☐ D63.1 Anemia in chronic kidney disease
☐ D64.9 Anemia, unspecified
☐ N18.3 Chronic kidney disease, stage 3 (moderate)
☐ N18.4 Chronic kidney disease, stage 4 (severe)
☐ N18.5 Chronic kidney disease, stage 5
☐ N18.9 Chronic kidney disease, unspecified
☐ Other:_____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol, no recommended standard pre-meds
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

*If applicable, FlexCare will substitute drug per payer guidelines. To prohibit substitution, check here ☐
☐ Injectafer 750mg IV x2 doses separated by approximately 7 days
☐ Venofer 200mg IV x5 doses separated by approximately 2 to 7 days
☐ Venofer 300mg IV x3 doses separated by approximately 3 to 7 days (OB/GYN indications only)
☐ Feraheme 510mg IV x2 doses separated by approximately 3 to 8 days
☐ Monoferric 1,000mg IV once

☐ Other:_____
First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Flourish Health Group's protocol (See flourishhealth.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Flourish Health Group's protocol (See flourishhealth.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date