Richmond
7110 Forest Ave, Suite 203
Richmond, VA 23226

Prince George
2025 Waterside Rd, Suite 100B
Prince George, VA 23875

Physician Order - Venofer (iron sucrose)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:
Patient Weight: _____ kg _____ lb	Patient Height: _____ in

REFERRAL STATUS

☐ New Referral ☐ Dose/Frequency Change ☐ Order Renewal

Location Preference (optional)

☐ Richmond ☐ Prince George

* * If the patient has a central line - we need official placement report, diagnostic imaging to confirm tip placement and date of last access * *

DIAGNOSIS AND ICD-10 CODE

☐ Iron Deficiency Anemia D50.9
☐ Iron Deficiency Anemia due to blood loss D50.0
☐ Other: _____ ICD10 _____

Is your patient unable to tolerate, or had inadequate response to oral iron supplements? ☐Yes ☐ No

REQUIRED DOCUMENTATION (must include)

☐ This signed order form by the provider
☐ Patient Demographics AND Insurance Information
☐ CBC results, within 14 days
☐ Clinical/Progress Notes
☐ Labs and Tests Supporting Primary Dx
☐ Ferritin OR Iron Saturation results, within 14 days

Is your patient unable to tolerate, or had inadequate response to oral iron supplements? ☐Yes ☐ No

MEDICATION ORDERS

☐ Venofer 100mg infuse IV over 30 minutes 3 times weekly x _____ doses
☐ Venofer 200mg infuse IV over 30 minutes 3 times weekly x _____ doses*
☐ Venofer _____mg (*max 300mg per dose*) infuse IV over 30 minutes _____ weekly x _____ doses*

** **MAXIMUM** is 1000mg per 14 days*

OPTIONAL PREMEDICATIONS and LAB ORDERS

☐ Acetaminophen 650mg PO prior to infusion
☐ Diphenhydramine 25mg PO or IV (per patient preference) prior to infusion
☐ Methylprednisolone 40mg slow IVP prior to infusion
☐ Other PreMed and Lab Order with frequency:_____

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION		
Prescriber Name:	NPI:	Contact:
Phone:	Fax:	Email:
Prescriber Signature:		Date:

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com
Fax completed form and ALL required documentation to 804-554-5848
All information contained in this form is strictly confidential and will become part of the patient's record.