smartinfusion THERAPY SERVICES

Phone and Fax: 608-690-7210
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www.MySmartInfusion.com

Injectafer (ferric carboxymymaltose)

Infusion Order Form

Patient Information

Patient Name: _____DOB: _____ M ☐ F ☐

Allergies: _____

☐ New Treatment ☐ Continuing Treatment Last Treatment Date: _____ Next Due Date: _____

Diagnosis and ICD 10 Code (Required)

☐ Iron deficiency anemia ICD 10 Code: D50.9

Other: _____ ICD 10 Code: _____

Required Tests

Pregnancy Test Status & Date: _____

Required Labs (within 3 months & attach results)

Hgb Results _____
Ferritin Results _____
Iron Results _____
TSTAT Results _____
Serum Phosphate Results _____

Pre-Medication Orders

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg ☐ PO
Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
Methylprednisolone (Solu-Medrol) ☐ 125mg ☐ IV
Ondansetron (Zofran) ☐ 4mg ☐ 8mg ☐ PO ☐ IV
Other: _____ Route: _____
Dose: _____ Frequency: _____

Nursing

Provide nursing care per Smart Infusion Nursing Procedures, Including reaction management and post-procedure observation.

Special Instructions / Notes

Injectafer Medication Order

Patient Weight: _____KG

Dosage

☐ 750 mg ☐ 15mg/kg, not to exceed 1000 mg ☐ IV
Other: _____

Frequency

☐ Day 1, Day 8
☐ Single Dose
Other: _____

Required Documents

☐ Patient Demographic Sheet
☐ H & P within the past 6 months
☐ Current Medication List
☐ Clinical and Progress Notes

Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____