INJECTAFER infusion order

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____ _____
- ☐ _____ _____

PRE-MEDICATION

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____ *(other)*

ORDERS

DOSAGE

- ○ _____
- ◉ _____
- ○ _____

PATIENT WEIGHT

_____ lbs.

_____ kg

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

Please return by fax to: (806) 503-2200 or email to: referrals@icareama.com.