Washington MEDICAL CENTER

FAX: 636-330-2363 Phone: 636-202-9400

REFERRAL STATUS

NEW REFERRAL	ORDER RENEWAL

PATIENT INFORMATION

PATIENT NAME:	DOB:	SEX: M F
WEIGHT: LBS KG	PHONE NUMBER:	
ALLERGIES:	EMAIL:	

Please check that the following are included:	☐ Patient demographics and insurance attached	☐ Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached
	☐ Current Medication List:	

DIAGNOSIS

ICD-10 CODE: D50.9 (Iron Deficiency Anemia) OTHER:	DATE OF LAST INFUSION/INJECTION:

PHYSICIAN INFORMATION

PHYSICIAN NAME:	PHONE NUMBER:
PRACTICE NAME:	FAX NUMBER:
OFFICE CONTACT:	

MEDICATION ORDER

MEDICATION:	DOSING:	FREQUENCY:	NOTES/COMMENTS:
Injectafer/ferric carboxymatatic	**750mg**	**2 doses** **7 days apart**	

PHYSICIAN SIGNATURE ____________________ DATE (Order is Valid for One Year) __________

LAB ORDERS

☐ CMP ☐ CBC ☐ FERRITIN ☐ IRON TIBC ☐ OTHER __________

☐ Labs to be Drawn by Infusion Center Frequency __________ Standing Order? Yes No

TYPES OF ACCESS

☐ Peripheral ☐ PICC ☐ Midline ☐ Port ☐ Subcu ☐ I/M