



Location

Liverpool

New Hartford

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to (315) 457-4305

Phone (315) 457-3091

1. PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> Lbs <input type="checkbox"/> Kg
Patient Status: <input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy <input type="checkbox"/> Next due date (if applicable):	

2. PHYSICIAN INFORMATION

Physician's name:	NPI#:
License #: <input type="text"/>	TIN#: <input type="text"/>
DEA#: <input type="text"/>	
Address: <input type="text"/>	
City: <input type="text"/>	State: <input type="text"/>
Office contact: <input type="text"/>	Zip: <input type="text"/>
Office phone: <input type="text"/>	Email: <input type="text"/>
	Office fax: <input type="text"/>

3. DIAGNOSIS INFORMATION (and year of diagnosis)

Iron Deficiency Anemia **ICD 10** () Other (specify):

4. INSURANCE INFORMATION
Please submit copies of the front and back or primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION (requires new order every 12 months)

<p>IRON</p> <p>MONOFERRIC</p> <p><input type="checkbox"/> Over 50 kg: 1000 mg over at least 20 minutes</p> <p><input type="checkbox"/> Under 50 kg: 20 mg/kg over at least 20 minutes</p> <p>INJECTAFER</p> <p><input type="checkbox"/> Over 50 kgs: Administer 2 doses of 750 mg at least 7 days apart for a total dose of 1500 mg IV</p> <p><input type="checkbox"/> Under 50 kgs: Administer 2 doses at least seven days apart; each dose 15 mg/kg IV</p> <p><input type="checkbox"/> Vital signs per HI Protocol</p> <p><input type="checkbox"/> Anaphylaxis & Hydration Management per HI Protocol</p>	<p>PRE-MEDICATIONS <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg PO</p> <p><input type="checkbox"/> Fexofenadine (Allegra) 180mg PO (or other non-sedating anti-histamine)</p> <p><input type="checkbox"/> Diphenhydramine (Benadryl) <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> PO <input type="checkbox"/> IV (requires driver)</p> <p><input type="checkbox"/> Methylprednisolone (Solu-Medrol) <input type="checkbox"/> 40mg <input type="checkbox"/> 80mg <input type="checkbox"/> 125mg IV</p> <p><input type="checkbox"/> Prednisone <input type="text"/> mg PO</p> <p><input type="checkbox"/> Other: <input type="text"/></p> <p>POST-MEDICATIONS <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg PO</p> <p><input type="checkbox"/> Prednisone <input type="text"/> mg PO</p> <p><input type="checkbox"/> Other: <input type="text"/></p>
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6. LABS

<input type="checkbox"/> CBC w/Diff	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): <input type="text"/>
<input type="checkbox"/> CRP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): <input type="text"/>
<input type="checkbox"/> CMP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): <input type="text"/>
<input type="checkbox"/> ESR	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): <input type="text"/>
<input type="checkbox"/> Hepatic Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): <input type="text"/>
<input type="checkbox"/> Renal Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): <input type="text"/>
<input type="checkbox"/> Quantiferon TB Gold, annually, last completed (date): <input type="text"/>		
<input type="checkbox"/> Other (specify): <input type="text"/>		

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE _____

DATE _____