



eMediateINFUSION center

- New Prescription/Referral
- Prescription Refill

VENOFER

Rx:	Patient Name:	DOB:
MEDIATION/Strength: VENOFER		
<input type="checkbox"/> 200mg in 100ml NaCl over 15 mins x 5 doses via IV infusion over a 14-day period. Total = 1000mg. <input type="checkbox"/> 200mg IV push over 2 to 5 mins x 5 doses over a 14-day period. Total = 1000mg. <input type="checkbox"/> OTHERS:		
Dx: <input type="checkbox"/> Iron Deficiency Anemia (D50.9) <input type="checkbox"/> OTHERS (Dx + ICD Code 10):		
Pre-Medication:		
<input type="checkbox"/> Solumedrol 125mg IVP <input type="checkbox"/> Solu-Cortef 100mg IVP <input type="checkbox"/> Others:	<input type="checkbox"/> Tylenol _____ mg PO <input type="checkbox"/> 650mg <input type="checkbox"/> 975mg	<input type="checkbox"/> Benadryl _____ mg <input type="checkbox"/> 25mg <input type="checkbox"/> IV <input type="checkbox"/> 50mg <input type="checkbox"/> PO
		ANA Kit Protocol: <input type="checkbox"/> OK to use
Physician Signature		Date: (Valid for 1 year)
		NPI#: _____ DEA#: _____

PHYSICIAN INFORMATION

Physician Name:	CLINIC:
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Contact Information:		
Phone:	Fax:	Email:
	Other:	

Office Mailing Address:

Check that the following are included:

<input type="checkbox"/> Patient demographics & Insurance attached	<input type="checkbox"/> Lab Results	<input type="checkbox"/> Medication List
<input type="checkbox"/> Clinical progress notes	<input type="checkbox"/> Other Test Results	
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Diagnosis (supporting)	

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**702.268.8647
725.228.5220**

