



Venofer Order Form

Patient information			
Name	DOB	ULI	Allergies
Address	Phone Number	E-Mail address	Weight

Prescriber Information		
Name	Phone Number	Fax number

Clinical Information

Has patient trialed oral iron supplementation? YES NO

Has patient previously received IV iron and if so was there a reaction? YES NO Comments _____

Is patient under 18yrs old? YES NO (If yes, please refer patient to another facility)

Renew Infusions is not accepting pediatric orders at this time, please refer to local hospital or alternate facility.

Diagnosis	Hemoglobin	Ferritin
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Prescription

Dose: 100mg 200mg 300mg 400mg 500mg

Number of dose: _____ Interval: 4 weeks 6 weeks 2 months 3 months 6 months

Please note patients will require repeat HGB/Ferritin level prior to next dose if numerous doses orders

Previous history of reaction to any iron products, to give the following prior to infusion: <input type="checkbox"/> Methylprednisolone 125mg IV <input type="checkbox"/> Diphenhydramine 50mg PO/IV <input type="checkbox"/> Acetaminophen 650mg PO <input type="checkbox"/> Other: _____	For any adverse reaction DURING infusion to give the following: <input type="checkbox"/> Hydrocortisone 100mg IV <input type="checkbox"/> Diphenhydramine 50mg PO/IV <input type="checkbox"/> Acetaminophen 650mg PO <input type="checkbox"/> Dimenhydrinate 50mg PO/IV
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Prescriber Signature:

Date:

Please fax completed form and fax to Renew Infusions at 1-833-930-2673

Please advise patients they will receive a call from our nursing staff within 7 days. Infusion fee of \$225 will apply for infusions administered at Renew Infusions. Patient will be provided a receipt to be used for their Health Spending account (if applicable) or for income tax purposes. Prescriber will be notified if Renew Infusion staff is unable to contact patient or if patient declines infusion. A post infusion report will be faxed to prescriber once infusion is completed.