WEST TEXAS DIGESTIVE DISEASE CENTER

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Gastroenterology
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South Plains Infusion

IRON INFUSION

Name:_____ DOB:_____ M ○ F ○

Phone #1 :_____(H/W/C) Phone #2:_____(H/W/C)

Diagnosis:
○ **D50.9** Iron Deficiency Anemia ○ _____(other)

Please fax a copy of this order form and patient information to 1-806-302-1241 (must dial "1")

○ Demographics
○ H&P relevant diagnosis
○ Copy of front and back of insurance card
○ Current Medications
○ Current CBC, CMP
○ History of tried and failed therapy

Injectafer (ferric carboxmaltose)

○ **750 mg IV - 2 doses 1 week apart**

○ **Premeds:** _____

Venofer (Iron Sucrose)

○ **200 mg IV per protocol for 2 days**

○ **Premeds:**_____

ORDERING PROVIDER

Signature X_____ Date_____

☑ **Substitution Allowed**

Provider _____ Phone _____ Fax_____