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|  | | 625 S Pear Orchard Ridgeland, MS 39157  Phone: 769-233-8484 Fax: 769-233-8051 | | Iron  Enrollment Form | | |
| **Patient Information** | | | **Prescriber Information** | | | |
| Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Prescriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Gender: 🞎 Male 🞎 Female Last 4 of SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Insurance Information** (Please fax a copy of patient’s card including front and back) | | | | | | |
| **Medical Information** (Please attach clinical notes) | | | | | | |
| Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Patient’s Weight: \_\_\_\_\_\_\_\_ lb Height:\_\_\_\_\_\_\_ in | | | |
| **Prescription Information** | | |  | | | |
| **Medication** | **Dose/ Strength** | | **Directions** | | **Quantity** | **Refills** |
| 🞎 Venofer | 200 mg | | Infuse 200 mg IV every week x 5 doses | | 5 | 0 |
| 🞎 Injectafer | 750 mg | | Infuse 750 mg IV every 2 weeks x 2 doses | | 2 | 0 |
| Call physician immediately if any reaction occurs. PRN anaphylactic reaction: Stop infusion and call 911. Administer Epinephrine 0.3mg SC or IM, may repeat if needed. Administer Diphenhydramine 50 mg IV or IM. | | | | | | |
| Nursing Orders: RN to insert peripheral IV; Flush line with NS 0.9% per SAS | | | | | | |
| Prescriber’s Signature: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Product Substitution Permitted Date Dispense as Written Date | | | | | | |
| CONFIDENTIALY STATEMENT: This communication and any attachments is intended for the use of the designated recipients named above and may contain information that is privileged, confidential, and exempt from disclosure under applicable law if the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please destroy all copies of this communication and notify the sender immediately by telephone. | | | | | | |

Version 1