



Phone: (305)306-7147
Fax: (305)402-9559
Email: intake@clearwellinfusion.com

INFeD (Iron dextran)

PATIENT DEMOGRAPHICS

Patient Name:

Date of Birth: _____ M: F: Address: _____

Phone: _____ City, State, Zip: _____

Email: _____

Allergies:

PRIMARY DIAGNOSIS

ICD-10 Code:

DOCUMENTATION (PLEASE ATTACH)

Clinical / Progress Notes, Labs, Tests supporting primary diagnosis

Hemoglobin and hematocrit, serum iron, total iron binding capacity, serum ferritin and transferrin saturation

Clearwell Infusion Centers will draw maintenance labs unless otherwise directed by Referring Provider

PRE-MEDICATION

| | |
|--|---|
| <input type="checkbox"/> Acetaminophen 1000mg PO | <input type="checkbox"/> Solu-Medrol 125mg IVP |
| <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Solu-Cortef 100mg IVP |
| <input type="checkbox"/> Ceterizine 10mg PO | <input type="checkbox"/> Diphenhydramine 25mg IVP |
| <input type="checkbox"/> Loratadine 10mg PO | <input type="checkbox"/> Other: _____ |

PRIMARY MEDICATION ORDER

Dosage and Frequency

Infuse INFeD _____ mg _____ infusion(s) a week for _____ Patient Weight:
weeks for a total of _____ infusions. (**max daily dose is 100 mg) _____ lbs
_____ kg

NOTES

ORDERING PROVIDER

Provider Name: _____ NPI: _____

Practice Name: _____ Phone: _____

Office Contact: _____ Fax: _____

Practice Address: _____

City, State, Zip: _____

Provider Signature: _____ Date: _____