BrookWell
HEALTH

P 423.616.9757 TF 866.589.0003
www.brookwellhealth.com

Please FAX referral form and required clinical and demographic info to:

FAX: 844.309.6361

Injectafer Referral Form

PATIENT INFORMATION	PROVIDER INFORMATION
Name______________ DOB__________	Name______________ NPI__________
Address______________	Address______________
City__________ State_____ Zip_______	City__________ State_____ Zip_______
Phone __________ Alt. Phone __________	Phone__________ Fax__________
Email __________ Gender ☐M ☐F	Office Contact __________ Phone__________

REQUIRED ✓Insurance Card Front/Back ✓Prescription Insurance Card Front/Back ✓Clinical Notes ✓Lab/Test Results

CLINICAL INFORMATION

Primary Diagnosis (ICD-10): ____________ **Diagnosis Description:** ______________________

Secondary Diagnosis (ICD-10): __________ **Diagnosis Description:** ______________________

Drug Allergies: ______________________ **Latex Allergy:** ☐ **Yes** ☐ **No**

Height________ **(in) Weight**________**(lbs)** **Iron Level:** __________ **Ferritin Level:** __________

Line Access: ☐ **PIV** ☐ **Port** ☐ **PICC** ☐ **Midline** **Initial Infusion:** ☐ **Yes** ☐ **No (If NO, date of last infusion:**____________**)**

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
☐ **Injectafer** (Ferric carboxymaltose)	750mg/15m Vial	☐ Inject/Infuse 750mg IV at least 7 days apart for 2 doses	2 Doses	None
		☐ Inject/Infuse 15mg/kg IV at least 7 days apart for 2 doses	2 Doses	None
		☐ Inject/Infuse _______mg IV at least 7 days apart for 2 doses	2 Doses	None
		☐ Inject/Infuse _______mg IV as directed		
☐ **Other**				

My signature below certifies that (1) The above-named individual is my patient and the therapy identified has been deemed medically necessary. (2) All information provided is true and accurate to the best of my knowledge. (3) I authorize the use of BrookWell Health's Infusion and line access and flushing protocols. (4) I authorize BrookWell Health to perform any necessary emergency and/or anaphylaxis treatment as per BWH protocol.

Provider Name ______________________ **Provider Signature** ______________________ **Date** ____________

BW - INJECTAFER -V.C21