FLEXCARE INFUSION CENTER

Please mark closest FlexCare location:
☐ Oklahoma City, OK ☐ Norman, OK
☐ Tulsa, OK ☐ Birmingham, AL

CONTACT INFORMATION
Fax: (888) 219-8102
Email: orders@flexcareinfusion.com
Visit: flexcareinfusion.com/referrals

PRIMARY CARE REFERRAL FORM

PATIENT INFORMATION

PATIENT NAME:
DATE OF REFERRAL:
SOCIAL SECURITY NUMBER:
DATE OF BIRTH:
PRIMARY DIAGNOSIS ICD-I0 CODE:
HEIGHT: ____ Ft ____ In WEIGHT: ____Lb or ____Kg
GENDER: ☐ F ☐ M
ALLERGIES: NKDA ☐

PREFERRED CONTACT #:
SECONDARY CONTACT #:
ADDRESS:
CITY, STATE, ZIP:

FIRST DOSE: ☐ Y ☐ N NEXT DOSE DUE BY: _____
DATE OF LAST INFUSION / INJECTION: _____
ACCESS/LINE TYPE: ☐ PIV ☐ PORT ☐ PICC ☐ MIDLINE

REQUIRED DOCUMENTATION:

ALL PATIENTS
- ☐ Insurance Card (Front & Back)
- ☐ Patient Demographics
- ☐ Current Medication List
- ☐ H & P
- ☐ Most recent labs

PROLIA, EVENITY & ZOLEDRONIC ACID
- ☐ Bone Scan
- ☐ Most recent labs including Ca+ level within the past 3 months

INJECTAFER
- ☐ Most recent Ferritin, Hemoglobin, and Hematocrit

PRIMARY MEDICATION ORDER:

OSTEOPOROSIS:
- ☐ PROLIA 60mg subcutaneously, every 6 months
- ☐ EVENITY 210mg subcutaneously monthly (2 x 105mg pre-filled syringes)
- ☐ Zoledronic Acid 5mg IV every 12 months

IRON DEFICIENCY ANEMIA:
- ☐ INJECTAFER 15mg/kg IV not to exceed 1500mg on day 0 and 7 (for patients 50kg or <)
- ☐ INJECTAFER 750mg IV on day 0 and 7 (for patients >50kg)
- ☐ Infed _____ mg IV over _____ day(s)
- ☐ Fereheme 510mg IV on day 1 and day _____ (3-8 days after 1st infusion recommended)
- ☐ Other Orders:

_____

_____

LABS:

☐ CBC ☐ CBC with diff ☐ CMP
☐ Other: _____

FREQUENCY: _____

PRN AND PREMEDICATIONS:

	Prior to every infusion	PRN
Acetaminophen ___ mg PO	☐	☐ PRN every ____ hours after infusion.
Diphenhydramine ___ mg PO	☐	☐ PRN every ____ hours after infusion.
Diphenhydramine ___ mg diluted in 10mL 0.9% NaCl slow IV push over 2-3 min.	☐	☐ PRN every ____ hours after infusion.
Methylprednisolone ___ mg IV push over 5 minutes.	☐	☐ _____
0.9% NaCl ___ mL to infuse over ___ minutes.	☐	☐ _____

LINE USE/CARE ORDERS (if applicable)

- ☑ START PIV/ACCESS CVC
- ☐ OTHER FLUSH ORDERS:
- ☑ FLUSH DEVICE PER FLEXCARE INFUSION POLICY & PROCEDURE (See Reverse Side)

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

- ☑ ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER FLEXCARE INFUSION POLICY AND PROCEDURE (See Reverse Side)
- ☐ OTHER: (please fax other reaction orders if checking this box)

PRESCRIBER INFORMATION:

PHYSICIAN NAME:
OFFICE CONTACT:
ADDRESS:
CITY, STATE, ZIP:

PHONE:
FAX:
LICENSE #:
NPI:

PHYSICIAN SIGNATURE: DATE: