



PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION	
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____	Prescriber Name: _____ State License: _____ NPI #: _____ DEA: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____ Phone: _____		
INSURANCE INFORMATION – OR – Send a copy of the patient’s prescription/insurance cards (front & back)			
Primary Insurance: _____ City, State, Zip: _____ Plan #: _____ Group #: _____ Phone: _____	RX Card (PBM): _____ BIN: _____ PCN: _____ City, State, Zip: _____ Group #: _____ Phone: _____		
CLINICAL INFORMATION			
Diagnosis/ ICD 10 Code: <input type="checkbox"/> D50.9 Iron deficiency anemia <input type="checkbox"/> Other: _____ Lab work: Serum Ferritin level: _____ TIBC (iron % binding panel): _____ CBC: _____ Other: _____			
VENOFER ORDERS			
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____			
Medication	Directions	Quantity/Refills	
<input type="checkbox"/> Venofer (iron sucrose) 300mg IV	Mix in 100-250ml NS. Give over 30 minutes per 100mg of drug. Repeat dose every _____ weeks.	Quantity: _____ Refills: _____	
SIGNATURE			
We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.			
X _____ <div style="text-align: center;">Prescriber Signature</div>		Date: _____	

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.