



FAX REFERRAL: **800-970-6020**



Feraheme Referral Checklist

Date: / / .

Referring Physician: _____.

Physician's Telephone #: _____ Facsimile #: _____.

Patient's Name: _____ Date of Birth: / / .

- Patient Demographics
- Most Recent Office Visit Note
- Laboratory (CBC, BMP, serum iron, total iron binding capacity –TIBC, and % saturation)
- Order for Feraheme – Signed by Prescriber
 - Allow Physician/Pharmacist to subsequently monitor serum iron indices and dose Feraheme

Comments:

Office Staff Name: _____ Signature _____.