



**Edward Cancer Centers**

120 Spalding Drive; Suite 111; Naperville, IL 60540  
Phone: 630/646-2273 Fax: 630/548-6617

24600 West 127<sup>th</sup> Street; Plainfield, IL 60585  
Phone: 630/646-2273 Fax: 630/548-6617

177 E. Brush Hill Road Elmhurst, IL 60126  
Phone: 630/646-2273 Fax: 331/221-3887

**Iron Infusion Orders**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**\*\*\*Please include current history and physical and any recent labs/tests, if applicable\*\*\***

**\*PLEASE ATTACH COPY OF INSURANCE CARD WITH THIS ORDER\***

**Pre-Authorization #  
or Call Reference #:** \_\_\_\_\_

(Ordering Physician Office is Responsible to Obtain Authorization/Referral)

**Contact Name and Phone**

**Number of Insurance Company:** \_\_\_\_\_

If you have any questions regarding pre-authorizations, please contact (630) 527-3788 and ask for the billing department.

Diagnosis (ICD-10 Required): \_\_\_\_\_

Patient's Weight (lbs/kg): \_\_\_\_\_ Patient's Height: \_\_\_\_\_

Is this their first dose?  Yes  No Date of Previous Dose: \_\_\_\_\_

**Drug:** \_\_\_\_\_

**Dose:** \_\_\_\_\_ **Number of Doses:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_

**In the event of a hypersensitivity reaction during the infusion of this medication, we will implement the reaction protocol. A designated nurse practitioner will evaluate your patient and your office will receive notification of the event.**

**In the event that your patient has a central line, it will be used per the Cancer Center protocol, unless otherwise directed.**

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Ordering Physician NPI:** \_\_\_\_\_ **Swedish Hospital NPI:** 1831151257

\_\_\_\_\_  
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\_\_\_\_\_  
**Physician Name (Please Print)**

\_\_\_\_\_  
**Office Phone**

\_\_\_\_\_  
**Fax Number**