

VITAMIN B 12 INJECTION (CYANOCOBALAMIN INJECTION) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____
 Mobile Number: _____ Patient Weight: _____ kg
 Allergies: _____
 Patient has known difficult venous access. Comments: _____

DIAGNOSIS (Provider must specify)

Vitamin B12 deficiency anemia, ICD 10: D51.9
 Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____
 Signature: _____ Date: _____
 Contact Name: _____ Phone: _____ Fax: _____
 Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

- Demographics Labs and tests supporting diagnosis Office/progress notes

PRE-MEDICATION (Not typically indicated)

Acetaminophen (Tylenol) 500 mg PO Famotidine 20 mg IV Methylprednisolone (Solu-Medrol) 125 mg IVP
 Benadryl 25mg PO Cetirizine (Zyrtec) 10 mg PO
 Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Vitamin B 12 Injection	1000mcg	IM or Sub Q	Every _____ <input type="checkbox"/> days <input type="checkbox"/> weeks <input type="checkbox"/> months For _____ <input type="checkbox"/> days <input type="checkbox"/> weeks <input type="checkbox"/> months or <input type="checkbox"/> _____ visits

New Start Therapy Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

FAX NUMBERS:

- CT: 203.433.0621 MA: 413.296.8482 NC: 919.984.8698 NY: 631.250.6020 SC: 864.973.6279
 FL: 904.877.9270 MD: 240.224.8607 NH: 603.217.5371 OH: 937.871.4594 VA: 703.202.0499
 ME: 207.407.7272 NJ: 201.581.4521 PA: 610.273.5998