

# VITAMIN B 12 INJECTION (CYANOCOBALAMIN INJECTION) ORDER FORM

## PATIENT INFORMATION

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

Mobile Number: \_\_\_\_\_ Patient Weight: \_\_\_\_\_

Allergies: \_\_\_\_\_

## 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 | <input type="checkbox"/> 1000mcg | <input type="checkbox"/> IM or Sub Q | Every ____<br><input type="checkbox"/> days <input type="checkbox"/> weeks<br><input type="checkbox"/> months<br>For ____<br><input type="checkbox"/> days <input type="checkbox"/> weeks<br><input type="checkbox"/> months or ____ visits |

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

## LABS / SPECIAL INSTRUCTIONS

**FAX NUMBERS:**  CT: 203.433.0621     ME: 207.407.7272     NH: 603.217.5371     NJ: 201.581.4521

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