SOLIS MEDICAL CLINIC

Multidisciplinary Chronic Pain
"Helping You Create Better Health"

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MONFERRIC / VENOFER order form

Patient information

Name: _____ DOB: _____ Weight: _____ PHN: _____

Address: _____ Allergies: _____ Phone number: _____ Emergency Contact: _____

Prescriber Information

Name: _____ Office/Clinic: _____ Phone number: _____ Fax number: _____

Clinical information:

Is patient pregnant, breastfeeding or under age 18? _____NO _____YES Please prescribe Venofer instead as Monoferric is not currently approved for use in pregnancy/lactation or patients under age 18 in Canada.

Diagnosis: _____Patient Hemoglobin: _____g/L Ferritin:_____

Has patient tried oral iron supplementation? _____ YES _____ NO

Comments: _____

Has patient received IV iron previously and if so, was there a reaction?

Details: _____

Prescription (A) Monoferric (iron isomaltoside) to be administered by IV infusion as per product monograph.

Simplified Monoferric weight based table

HB (g/L)	Body weight under 50 kg	Body weight 50kg up to 70kg	Body weight 70kg or more
At or above 100	500mg	1000mg	1500mg
Less than 100	500mg	1500mg	2000mg

*Doses greater than weight based chart above, or exceeding 20mgiron/kg body weight, or exceeding 1500mg must be divided into multiple doses separated by at least 7 days (ie < Induction dose). If the dose is not clearly stated on this form, administration guidelines as per product monograph will be followed.

Dose: _____ 500mg _____ 1000mg_____1500m_____ 2000mg (Induction Dose)

Prescription (B) Venofer (200mg/100mls 0-9% Saline) _____ 5 treatments over 14 days or _____

Total number of doses: _____Interval: _____2 months _____3 months _____6months _____ other:

Note: Prescribers are responsible for ordering and monitoring patient blood work as well as notifying infusion clinic as soon as patient no longer requires above treatment.

If the patient has a history of reaction to any iron products: Give: ___ Methylprednisolone 125mg IV ___Diphenhydramine 25-50mg PO/IV ___ Acetaminophen 650mg PO ___ Other _____	If the patient has adverse reaction during/post infusion: Give: ___ Hydrocortisone 100mg IV ___ Methylprednisolone 125mg IV ___ Diphenhydramine 25-50mg PO/IV ___Acetaminophen 650mg PO ___Dimenhydrinate (Gravol) 25-50mg PO/IV

** Current infusion reaction includes the use of above medications according to nurse's assessment

Prescriber Signature: _____ Prescriber Name (Printed): _____Date: _____

Please fax the completed form to 587-805-2539.