Multidisciplinary Chronic Pain
"Helping You Create Better Health"

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MONOFERRIC / VENOFER / FERINJECT order form

$115 Administration Fee / In-House Pharmacist

We accept teenagers, and 2nd or 3rd trimester pregnancy (fetal heart rate monitoring available)

Patient information

Name: ______________________________DOB: _______________________Weight: __________________________PHN: _____________________

Address: ___________________________Allergies: _____________Phone number: ________________Emergency Contact: ___________________

Email(required):____

Prescriber Information

Name: ___________________Office/Clinic: ____________________Phone number: __________________Fax number: __________________

Clinical information:

Patient pregnant___________Breastfeeding_____________Under age 18____________

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.

Dose: ______500mg ______1000mg______1500mg Dilute in normal Saline: 100ml__________________250ml__________

Prescription (B) Venofer (200mg/100mls Normal Saline) _________ 5 treatments over 14 days or _______________

Prescription (C) Ferinject Under 65kg 500mg_______ Over 65kg 1000mg________ Dilute normal Saline: 100ml______

Prescription (D) Normal Saline Bolus 250ml pre-infusion_________post-infusion___________

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

By faxing, the prescriber confirms patient consent for Iron clinic and affiliated pharmacy to contact the patient.