

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 Address(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 _____ 6 months _____ 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
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** 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 Solis Medical Clinic and affiliated pharmacy to contact the patient.