PROXIMA HEALTHCARE

IRON Order Form

647-577-1553
647-777-6118
ADMIN@PROXIMAHEALTH.CA
ONLINE BOOKING: PROXIMAHEALTH.CA/INFUSION-CLINIC/

PATIENT INFORMATION (fill out patient information or affix patient label)

Full name: _____ Date of birth (DD/MM/YYYY): _____

Address: _____ City: _____ Province: _____ Postal code: _____

Preferred phone: _____ Alternate phone: _____ Email: _____

Health card #: _____ Allergies: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

PRESCRIPTION INFORMATION

Diagnosis: _____ Hemoglobin: _____ g/l Ferritin: _____ ng/mL

Patient weight: _____ lbs _____ kg Date of weight (DD/MM/YYYY): _____ Pregnant? ☐ YES ☐ NO

New to Iron Infusions?: ☐ YES ☐ NO If no, indicate reaction details, if applicable: _____

MEDICATION

☐ **Ferinject** Maximum dose for treatment: 15 mg/kg | Maximum dose per week: 1000mg. Treatment dose will be split according to bodyweight.

Pregnancy: Maximum cumulative dose (gestation week ≥16) is restricted to 1000mg for patients with Hb >9 g/dL or 1500mg in patients with Hb ≤9 g/dL.

Hb (g/dL)	Bodyweight <35 kg	Bodyweight 35 kg to <70 kg	Bodyweight ≥70 kg
<10	☐ 500 mg	☐ 1500 mg	☐ 2000 mg
10 to <14	☐ 500 mg	☐ 1000 mg	☐ 1500 mg
≥14	☐ 500 mg	☐ 500 mg	☐ 500 mg

☐ **Monoferric** Maximum dose for treatment: 20mg/kg | Maximum dose per day: 1500mg. Treatment dose will be split according to bodyweight.

Pregnancy: Maximum single dose (gestation week ≥16) is restricted to 1000mg and max cumulative dose is restricted to 2000mg

Limited use code (if applicable): ☐ 610

Hb (g/dL)	Bodyweight <50 kg	Bodyweight 50 kg to <70 kg	Bodyweight ≥70 kg
<10	☐ 500 mg	☐ 1500 mg	☐ 2000 mg
≥10	☐ 500 mg	☐ 1000 mg	☐ 1500 mg

Hb Levels should be re-assessed no earlier than: 4 weeks post final Iron administration.

In the event the patient requires further iron repletion the iron need should be recaluclated and a new Medical Order provided.

☐ **Venofer** Maximum dose for treatment course: 1000 mg | Maximum dose per day: 300 mg (recommended two to three days between doses)

TREATMENT INTERVAL

Every _____ week(s)

Number of treatments: _____

DOSE

☐ 100mg in 100mL NS over at least 30 min
☐ 200 mg in 100 mL NS over at least 60 min
☐ 300 mg in 250 mL NS over at least 90 min
☐ Other: _____ mg in NS over at least _____ min

OTHER TREATMENTS

PRE-INFUSION (only required if prior reaction)

_____

_____

_____

PRN FOR REACTION

☐ Acetaminophen: 325–650 mg PO
☐ Dimenhydrinate: 25–50 mg PO/IV
☐ Diphenhydramine: 25–50 mg PO/IV
☐ Epinephrine: (1:1000) 0.01 mL/kg (max 0.5 mL) SC/IM
☐ Hydrocortisone: 100 mg IV
☐ Methylprednisolone IV: _____ mg
☐ Oxygen via mask/nasal prongs 2–5 L/min IV: _____ mg
☐ Salbutamol Inhaler
☐ Salbutamol Nebulizer
☐ Other: _____

PREFERRED LOCATION FOR PATIENT TREATMENT

☐ PROXIMA HEALTHCARE **101-320 MATHESON BLVD WEST. MISSISSAUGA, ONTARIO, L5R 3R1**
P: 647-577-1553 F: 647-777-6118

PRESCRIBER SIGNATURE

Signature: _____ Date: _____ DD/MM/YYYY

PRESCRIBER INFORMATION

Prescriber name: _____ License #: _____

Address: _____ City: _____ Province: _____ Postal code: _____

Contact name: _____ Phone: _____

Fax: _____ Email: _____

Please note, a sitting fee applies to each infusion.

UPON COMPLETION FAX TO: **1-647-777-6118**