TOTAL LIFE CARE MEDICAL
250-7155 Kingsway, Burnaby
604-438-9991

IV IRON Order Form

FAX TO : 604-438-9960

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

Name: _____ Date of birth (DD/MM/YYYY): _____

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

Preferred phone: _____ Alternate phone: _____ Email: _____

Health card PHN#: _____ Allergies: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

PRESCRIPTION INFORMATION

Hgb:_____ DATE:_____

Ferritin:_____ DATE:_____

Transferrin Saturation:_____ DATE:_____

Patient weight:_____

Date of weight (DD/MM/YYYY):_____

MEDICATION

☐ **Ferinject**

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

Simplified weight base table: for IV infusion. Must be diluted in sterile 0,9% sodium chloride solution

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

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

Comments

OTHER TREATMENT - PRN/PRE Medications

- ☐ Acetaminophen 325-650 mg PO PRN q 4-6 hours for pain, fever or chills
- ☐ Diphenhydramine 25-50 mg PO/IV PRN q 4-6 hours for itching, uticaria,puritis, hives
- ☐ Dimenhydrinate 25-50 mg PO/IV PRN q 4-6 hours for nausea and vomiting
- ☐ Hydrocortisone 100 mg IV PRN x 1 for anaphylactic reaction
- ☐ Epinephrine (1:1000) 0.01 mL/kg (max 0.5 mL) SC/IM PRN q 10-15 minutes x 2 for severe anaphylactic reaction
- ☐ Oxygen via mask/nasal prongs 2-5 L/min PRN for SOB or decreasing 02 sat (below 90% if lower than baseline)
- ☐ Salbutamol 2 puffs q 4-6 hours via aerochamber PRN for dyspnea or wheezing
- ☐ Salbutamol 2.5 mg nebule for inhalation by nebulizer PRN for dyspnea or wheezing x 1 dose

PRE-Medications : _____

Other Instructions: _____

Has the patient ever had an infusion reaction to iron in the past? Yes_____ No_____

If yes, please specify: _____

Does the patient have asthma or inflammatory arthritis?Yes_____ No_____

Other allergies: _____ Is the patient pregnant? Yes_____ No_____

PRESCRIBER SIGNATURE

Signature: _____ **Date:** _____ DD/MM/YYYY

PRESCRIBER INFORMATION

Prescriber name: _____ License #: _____

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

_____ Phone: _____

Fax: _____ Email: _____