

Ferinject IV Iron Referral Form – DIN# 02546078

PATIENT INFORMATION or affix patient label

Last Name: _____ Date of Birth: DD/MMM/YYYY
First Name: _____ Health Card#: _____ Version Code: _____
Address: _____ City: _____
Email: _____ Cell: _____
Allergies: _____
Emergency Contact: _____ Emergency Contact Cell: _____

CLINICAL DETAILS

Hemoglobin: _____ g/L Ferritin: _____ ng/mL TSAT (if applicable): _____ %
Patient Weight: _____ kg Date of Weight: DD/MMM/YYYY Pregnant? YES NO
Patient's first iron infusion? YES NO
If no, provide reaction details, if applicable: _____
Reason for low iron low intake
(if known): recent surgery other: _____
If unknown, what further investigations are underway?: _____

FERINJECT DOSING – check one box below

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

For pregnancy: Maximum cumulative dose (gestation week ≥ 16) is restricted to:
1000mg for patients with Hb >90g/L OR 1500mg for patients with Hb ≤ 90 g/L

Hb (g/L)	Bodyweight <35kg	Bodyweight 35kg to <70kg	Bodyweight ≥ 70 kg
<100	<input type="checkbox"/> 500mg	<input type="checkbox"/> 1500mg	<input type="checkbox"/> 2000mg
100 to <140	<input type="checkbox"/> 500mg	<input type="checkbox"/> 1000mg	<input type="checkbox"/> 1500mg
≥ 140	<input type="checkbox"/> 500mg	<input type="checkbox"/> 500mg	<input type="checkbox"/> 500mg

PRESCRIBER'S INFORMATION

Prescriber's Name: _____ License #: _____
Prescriber's signature: _____ Date: _____