FERINJECT® IV IRON INFUSION

REFERRAL & PHYSICIAN ORDER FORM

455 Harry Walker Pkwy S, Unit 7, Newmarket, ON L3Y 8T3 · Tel 905-431-9531 · Fax 905-235-1334

PATIENT INFORMATION

Name: _____ DOB: _____ Health Card #: _____

Address: _____

Phone: _____ Email: _____

REFERRAL REQUIREMENTS

Please attach bloodwork performed within the past 6 weeks, including **CBC**, **ferritin**, and (if available) **serum iron**.

CLINICAL INFORMATION

Reason for referral: _____

Previous IV iron: ☐ No ☐ Yes Date: _____ Reaction / response: _____

Allergies: _____

Pregnancy status: ☐ Not pregnant ☐ Pregnant, _____ weeks ☐ Unknown

PRESCRIBER ORDER

Patient Weight: _____ kg **Hb:** _____ g/L

Ferinject® (ferric carboxymaltose) — tick the applicable dose:

Hb (g/L)	< 35 kg	35 – <70 kg	≥ 70 kg
< 100	☐ 500 mg	☐ 1500 mg	☐ 2000 mg
100 – <140	☐ 500 mg	☐ 1000 mg	☐ 1500 mg
≥ 140	☐ 500 mg	☐ 500 mg	☐ 500 mg

Maximum 1000 mg per infusion; treatment dose split according to bodyweight. Pregnancy (≥16 weeks): maximum cumulative dose 1000 mg if Hb >90 g/L, 1500 mg if Hb ≤90 g/L.

Emergency Medications

☐ Epinephrine 0.3 mg IM PRN ☐ Diphenhydramine _____ mg PO/IV PRN

☐ Other: _____

INFUSION SCHEDULE

☐ **Single Visit:** ☐ 500 mg ☐ 1000 mg

☐ **Two Visits:** Visit 1: 1000 mg Visit 2: ☐ 500 mg ☐ 1000 mg

Maximum 1000 mg per infusion.

REFERRING PROVIDER

Name: _____ Billing #: _____

Clinic: _____ Phone: _____

Fax: _____ Signature: _____ Date: _____

UPON COMPLETION, FAX TO 905-235-1334