SANDSTONE INFUSION CLINIC
Glenmore Landing
Suite D274 1600 90 Ave SW Calgary T2V 5A8
P: (403) 255-4200 ext. 7 F: (403) 236-0846
GLInfusionClinic@nbly.ca

Name:
DOB: (MM/DD/YYYY)
PHN:
Ph#:

Iron Deficiency IV Infusion Order Form

Indication

Last iron infusion received - Date: _____ Product: _____ ☐ N/A

Is the patient pregnant? ☐ No ☐ Yes *(Monoferric® should not be used. IV iron contraindicated in 1st trimester.)*

ferritin: _____ µg/L **Hgb**: _____ g/L

test date: _____

Repletion

1. Patient has low ferritin suggesting iron deficiency
2. **AND** has at least 1 of the following:

☐ symptoms of iron deficiency ▶ Describe:_____ ☐ asymptomatic but with Hgb less than 70 g/L

☐ failure to respond to adequate trial of oral iron in compliant patient ☐ intolerance to oral iron therapy ▶ Describe: _____

☐ malabsorption ▶ Describe: _____

☐ **Maintenance** ▶ Diagnosis: _____

☐ **Other Indication**: ▶ Describe: _____

Order

Iron sucrose (Venofer®)

Dose (choose 1):

☐ 300 mg IV

☐ other: _____ mg IV

→

Frequency & duration (choose 1):

☐ No repeat

☐ Repeat the selected IV iron dose every _____ week(s) x _____

☐ other: _____

Iron isomaltoside (Monoferric®)

Dose (choose 1): *Max allowable dose per infusion is 20mg/kg*	Hgb (g/dL)	bodyweight < 50kg	bodyweight 50kg to < 70kg	bodyweight ≥ 70kg
	≥ 10	☐ 500 mg	☐ 1000 mg	☐ 1500 mg
	< 10	☐ 500 mg	☐ 1500 mg	☐ 2000 mg

Frequency & duration:

IV as a single dose given once

Patient Weight:_____

For obese patients it is recommended to use patient's ideal body weight for dosing

Nursing Orders: Dilute and infuse medication as per drug monograph and provide any PRN or emergency medications, or oxygen, as may be required while responding to an infusion reaction or in case of an emergency. Observe the patient for at least 30 minutes post-infusion.

Safety

Does the patient have any allergies?

☐ No ☐ Yes ▶ List all allergies and reactions:

Has the patient ever had an adverse reaction to an infusion?

☐ No ☐ Yes ▶ List all products and reactions:

PRESCRIBER INFORMATION

Name: Date:

Signature: Ph:

Fax:

CONFIDENTIALLY FAX WITH THE PATIENT'S CONSENT TO: Sandstone Pharmacies **Fax #: 403-236-0846**