ACCESS HEALTHCARE SERVICES

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IRON
Order Form

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

Full name:_____ Date of birth: (DD/MM/YYYY) _____
Address:_____ City:_____ Province: _____ Postal Code: _____
Phone Number: _____ Alternate Phone: _____ Email: _____
Health Card#: _____ Allergies: _____
Emergency Contact Name : _____ Emergency Contact Phone : _____

PRESCRIPTION INFORMATION

Diagnosis: _____ Patient weight: _____ Date of weight (DD/MM/YYYY): _____
Hemoglobin: _____ g/L Ferritin: _____ug/L TSAT: _____% New to Iron Infusions? ☐ YES ☐ NO
Relevant Medical History/Notes: _____
Indicate previous reaction details* ☐None ☐Mild ☐Moderate ☐Severe Description (reqd): _____
Orders for pre-infusion antihistamine and/or IV corticosteriods (if required)_____
Is the patient pregnant? ☐ No ☐ Yes (If yes complete the section below) **If pregnant patient has had previous reaction refer to local MDCU*

PREGNANT PATIENTS

Gestation ____ weeks High Risk Pregnancy? ☐ Yes ☐ No
Have the risks of receiving IV iron during pregnancy been reviewed with the patient? ☐ Yes ☐ No
Note: Fetal monitoring is not conducted during the infusion
Is the patient's Obstetrician aware and have they approved the patient for an IV iron infusion? ☐ Yes ☐ No *If not the Obstetrician complete below
☐ I am the patient's Obstetrician *Obstetrician Name: _____Ph:_____Fax:_____

MEDICATION

Ferinject Maximum dose for treatment: 15mg/kg — **Maximum single infusion dose: 1000 mg** — Treatment dose will be split according to bodyweight.
Note: Maximum cumulative dose in pregnant patients (gestation week >16) is restricted to 1000 mg if Hb>90g/L and 1500 mg if Hb<90g/L.

Limited Use Code (if applicable): ☐ 735 ☐ 736
Treatment interval
☐ One Time Infusion ☐ Split dose
MD/NP Notes:

Simplified weight base table:

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

**All doses exceeding the maximum daily injection will require a separate infusion, at least 7 days later.*

Monoferric Maximum dose for treatment: 20 mg/kg – **Maximum single infusion dose: 1500 mg** – Treatment dose will be split according to bodyweight.
Note: Maximum cumulative dose in pregnant patients (gestation week >16) is restricted to 2000 mg. Maximum single dose in pregnant patients is restricted to 1000 mg.

Limited Use Code (if applicable): ☐ 610
Treatment interval ☐ One time infusion ☐ Split dose
MD/NP Notes:

Simplified weight base table:

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

**All doses exceeding the maximum daily injection will require a separate infusion, at least 7 days later.*

INTRAVENOUS ACCESS

☐ PIV ☐ PORT ☐ PICC ☐ Tunneled CVC

Flush and lock VAD with _____ml of _____ solution

PRESCRIBER DETAILS

Name: _____CPSO: _____ CNO: _____

Signature: _____ Date: _____

LOCATION FOR PATIENT TREATMENT

AICS CLINIC

AICS Clinic
Access Integrated Care Solutions
Suite 105
2526 Queensview Drive
Ottawa ON K2B 8K2

VISIT www.access-healthcare.com to download this form

PREFERRED PHARMACY PARTNER

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☐ Please check if you would like the AICS clinic to arrange supply & delivery of the medication to the clinic.