IRON PRESCRIPTION FORM

PRAESENTIA HEALTHSPAN

☐ Halifax

Patient Information

Patient Name:	Diagnosis:
DOB (DD/MM/YYYY):	Allergies:
Phone:	**Patient Weight**(kg)**:** **Date of Weight**(DD/MM/YYY)**:**
Email:	**Hgb Levels:** **Ferritin Levels:**
Is the patient: • Under 18 • Pregnant or breast feeding • History of reactions to iron • Has multiple drug sensitivities • Mast-cell disorders or moderate to severe asthma ☐ Yes ☐ No If yes to the above, please refer the patient to the hospital.	Does the Patient have a history of medication reactions? ☐ Yes ☐ No Please consider infusion related medications below. Does the patient have history of previous Iron Infusions? ☐ Yes ☐ No Date of last infusion (DD/MM/YYYY): _____

Iron Prescription

☐ **Monoferric** Maximum dose for treatment: 20mg/kg.

Maximum single dose 1500mg. >1500mg will be divided into 2 doses, a minimum of 7 days apart.

Hb (g/L)	>50kg	50-70kg	≥70kg
<100	☐ 500mg	☐ 1000mg + 500mg	☐ 1000mg + 1000mg
≥100	☐ 500mg	☐ 1000mg	☐ 1000mg + 500mg

Infusion time: All doses are administered in 250ml NS over 45 minutes.

☐ **Ferinject** Maximum dose for treatment: 15mg/kg.

Maximum single dose 1000mg. >1000mg will be divided into 2 doses, a minimum of 7 days apart.

Hb (g/L)	35-70kg	≥70kg
<100	☐ 1000mg + 500mg	☐ 1000mg + 1000mg
>100 - 140	☐ 1000mg	☐ 1000mg + 500mg
≥140	☐ 500mg	☐ 500mg

Infusion time: All doses are administered in 100ml NS over 30 minutes.

Infusion Related Medication Options

For patients with **prior reactions**, the following **pre-medications are optional** ☐ Cetirizine 10-20mg ☐ PO Dimenhydrinate ☐ 25-50mg PO Tylenol 650mg PO	In the event of an **adverse reaction**, the following **medications** may be administered for **symptom management**: ☐ Cetirizine 10-20mg PO ☐ Dimenhydrinate 25-50mg PO/IV ☐ Tylenol 650mg PO ☐ Epinephrine 1:1000 .5mg IM

Prescribers Information

Prescriber's Name:	Phone Number:
Fax Number:	Billing Number:
Prescriber's Signature:	
Date (DD/MM/YYYY):	

Please fax completed form to 1-888-289-2507