CareMed WELLNESS CLINIC
Unit #105 7319 , 29 Avenue T6K2P1
587-200-8705

IRON ORDER FORM | MONOFERRIC & VENOFER

Please fax the completed form to **1-877-384-2278**

PATIENT DETAILS

NAME		DATE OF BIRTH (DD/MM/YYYY)	
PHONE		EMAIL	
ADDRESS		HEALTH CARD NUMBER	
EMERGENCY CONTACT NAME		EMERGENCY CONTACT NUMBER	

CLINICAL DETAILS

DIAGNOSIS		HEMOGLOBIN	g/l	FERRITIN	ng/mL
WEIGHT (KG)		ALLERGIES			

Is patient pregnant, breastfeeding, or under the age of 18?	☐ No ☐ Yes → Please prescribe Venofer instead as Monoferric is not currently approved for use in pregnancy/lactation or patients under age 18 in Canada. Please note that Venofer should not be given to pregnant women in the first trimester.
Has patient received IV iron previously?	☐ No ☐ Yes → Indicate if any reaction:

PRESCRIPTION

☐ MONOFERRIC

Simplified Monoferric Weight-Based Table

Hb (g/L)	<50kg	50-70kg	≥70kg
≥100	500mg	1000mg	1500mg
<100	500mg	1500mg	2000mg

Doses that exceed the weight-based chart above, 20mg iron/kg body weight, or 1500mg, must be split into multiple doses separated by at least 7 days (Induction Dose). If the dose is not clearly specified, the product monograph administration guidelines will be followed.

DOSE

☐ 500mg ☐ 1000mg ☐ 1500mg ☐ 2000mg (induction)
Total Number of Doses: _____
Interval: ☐ 2 months ☐ 3 months ☐ 6 months ☐ Other: _____

☐ VENOFER

Simplified Venofer Dosing Table

Max Dose for Treatment Regime = 1000mg

Max Daily Dose = 300mg

DOSING REGIMEN

☐ 200mg IV every _____ week(s) for _____ doses
☐ 300mg IV every _____ week(s) for _____ doses
☐ Other: _____ mg IV every _____ week(s) for _____ doses

OTHER MEDICATIONS

If the patient has a HISTORY of reaction to any Iron products, give the following medication IMMEDIATELY prior to the infusion:

☐ Methylprednisolone 125mg IV x1
☐ Diphenhydramine 25-50 mg PO/IV
☐ Acetaminophen 650 mg PO
☐ Other:

☐ Our clinics follow a standardized protocol to manage reactions during our post-infusion. Please tick this box to indicate that you agree with the following protocol. If the patient has adverse reaction DURING/POST infusion, give:

☐ Hydrocortisone 100mg IV
☐ Methylprednisolone 125mg IV
☐ Diphenhydramine 25-50mg PO/IV
☐ Acetaminophen 650mg PO
☐ Dimenhydrinate Gravol© 25-50mg PO/IV

Current infusion reaction protocol includes the use of these medications according to nurse's assessment.

ADDRESS		PHONE		FAX	
PRESCRIBER NAME		LICENSE NUMBER			
PRESCRIBER SIGNATURE		DATE (DD/MM/YYYY)			

Pharmacy of Choice

☐ HORIZON PHARMACY
On-site Partner Pharmacy

Prescriptions for iron infusions can be faxed directly to:
1-587-686-9855
Horizon Pharmacy has agreed to follow our required product integrity, handling, and storage requirements

☐ Other

_____