



MAGNESIUM ORDER FORM

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

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

PATIENT

Patient Full Name	PHN	DOB (dd-mm- yyyy)	Patient Weight (kg)
Contact Number	Address		
List of Allergies/ Reactions <input type="checkbox"/> NKDA			

PRESCRIBER

Name	Clinic/ Facility	Phone	Fax
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CLINICAL INFORMATION

Diagnosis: _____

Lab Values: Mg: _____ Date: _____ sCr: _____ eGFR: _____ Date: _____

Has patient tried oral magnesium supplementation: No Yes

Has patient received IV magnesium before No Yes – If YES, list any known reactions: _____

PRESCRIPTION

Magnesium Sulfate to be administered by IV infusion as per product monograph

Dose (select one): 2g 4g

Total Number of Doses: _____ Interval: Weekly Monthly 2 months 3 months

Note: Prescribers are responsible for ordering and monitoring patient blood work as well as notifying infusion clinic as soon as patient no longer requires above treatment.

If patient has a history of, or develops a reaction (before, during, or after infusion), Nurse may administer the following medications PRN, per Infusion Reaction protocol:

- Hydrocortisone 100 mg IV
 Methylprednisolone 125 mg IV
 Diphenhydramine 25–50 mg PO/IV
 Acetaminophen 650 mg PO
 Dimenhydrinate (Gravol®) 25–50 mg PO/IV
 Other: _____

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

Pharmacy of Choice

<input type="checkbox"/> 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

<input type="checkbox"/> Other _____
