WINNIPEG CLINIC – INFUSION CENTRE
425 ST. MARY AVE. – FIRST FLOOR
PHONE: (204) 957-3286
FAX: (204) 942-2044

IV IRON THERAPY REFERRAL FORM

Referring Health Care Provider:

Physician: _____

Address: _____

Phone: _____

Fax: _____

Patient Demographics:

Patient: _____

Address: _____

PHIN: _____

DOB: _____

Phone: _____

Treaty # (if applicable):

_____

CURRENT LAB RESULTS:

HGB: _____ **FERRITIN:** _____ **IRON:** _____

Eligibility for Insured Services/Medication: (Note: Patients with private insurance can still apply for EDS coverage, must meet deductible for the year even if approved by EDS)	
☐ Blue Cross ☐ Canada Life ☐ Green Shield ☐ Manulife ☐ Sunlife ☐ Other: _____ ☐ No Private Insurance	If there is no private insurance, complete exceptional drug status (EDS) form: ☐ Completed (Note: For those with Blue Cross coverage will need to show proof of EDS coverage prior to getting medication covered.)

Premedication:

- Diphenhydramine 25-50mg IV/PO X1
- Hydrocortisone 100mg IV X 1
- Dimenhydrinate 25-50mg IV/PO X 1
- Acetaminophen 325mg-650 PO x 1
- Epinephrine 0.3-0.5 mg IM or SC Q 10-15 minutes x 2-3 for anaphylaxis

PRESCRIBER SIGNATURE:

_____

DATE: _____

WINNIPEG CLINIC – INFUSION CENTRE
425 ST. MARY AVE. – FIRST FLOOR
PHONE: (204) 957-3286
FAX: (204) 942-2044

IV IRON THERAPY REFERRAL FORM

Intravenous Iron Prescribing Guidelines				
IV Iron Sucrose (Venofer)	Usual Dose: 100mg, 200mg, 300mg Maximum Daily Dose: 500mg		Dosage regimen once per week	
Ferric Derisomaltose (Monoferric)	Hemoglobin (g/L)	Total Iron Dose – Maximum dose per course of therapy per order		
		Bodyweight less than 50 kg	Bodyweight 50-69 kg	Body weight 70kg or greater
	100 or greater	500mg	1000mg	1500mg
	Less than 100	500mg	1000mg	1500mg

Prescriber Instructions: The prescriber MUST check the empty box to activate the corresponding order. An order with a black box will be activated UNLESS the prescriber crosses out the complete order with a line and initials. Signature: administer by IV infusion as directed per protocol.

☐ **MONOFERRIC IRON**	☐ **IRON SUCROSE**
500MG _____ **1000MG** _____ **1500MG** _____ **2000MG** _____ **FREQUENCY:**	**100 MG** ____ **200 MG** ____ **300 MG** ____ **500MG** ____ **600MG** ____ **FREQUENCY:**

PRESCRIBER SIGNATURE:

_____

DATE: _____

WINNIPEG CLINIC – INFUSION CENTRE
425 ST. MARY AVE. – FIRST FLOOR
PHONE: (204) 957-3286
FAX: (204) 942-2044

IV IRON THERAPY REFERRAL FORM

PRESCRIBER SIGNATURE:

_____

DATE: _____