



Please accept the following patient for Parenteral Iron Infusion

Patient Name	
DOB	
PHN	
Address	
Contact #	

**Ferritin & Hgb Level** [ ] Attached

**Relevant Medical History**

**Is the patient pregnant?** Y or N      **EDD** \_\_\_\_\_

**Prescription/Recommendation**

<p><b>Monoferric/Ferric derisomaltose</b>  <input type="checkbox"/> 500mg  <input type="checkbox"/> 1000mg  <input type="checkbox"/> 1500mg</p> <p>Sig: dilute dose in 0.9% saline, infuse via IV according to manufacturer's instructions</p>	<p><b>For low Ferritin with normal Hb:</b>          Ferritin &lt; 30 mcg: 1000 mg IV          Ferritin &gt; 30 mcg: 500 mg IV</p> <p><b>For Iron Deficiency Anemia (20mg/kg)</b>          Body Weight &lt; = 50 kg 500 mg          Body Weight 50 – 70 kg 1000 mg          Body Weight &gt; = 70 kg 1500 mg</p>
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**Venofer/Iron Sucrose** (pregnant patients)

200mg repeat x \_\_\_\_\_ every \_\_\_\_\_ weeks

Sig: dilute dose in 0.9% saline, infuse via IV according to manufacturer's instructions

**Referring Physician/PCP:**

**MSP/License Number:**

**Provider Signature:**

**Date signed:**

Please attached relevant documentation/lab results and fax to Nourish IV Clinic 778-478-0308 or email [info@nourishhealthclinic.ca](mailto:info@nourishhealthclinic.ca)

An RN will contact your patient to discuss the infusion and provide informed consent

Nourish IV will triage and offer appointments within 1-2 weeks