island health

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Adult Outpatient IV Iron
ORDER & BOOKING Form
Fax completed Form
Contact Medical Daycare for Fax #

Name: _____
DOB: _____ SEX: _____
PHN: _____
PATIENT PHONE # _____

DIAGNOSIS :

ALLERGIES:

SECTION A **ALL items in this section must be completed. EXCEPTION is for nephrologists only.**

1. IV IRON INDICATION (reserve for when oral iron has failed or is not an option)

- ☐ Iron deficiency anaemia (IDA) - acute treatment *
- ☐ Mixed IDA + anaemia of chronic disease - acute treatment *

Reserve for Hgb less than 110 g/L and proof of iron deficiency

- ☐ Preoperative iron for reducing transfusion requirement of surgery AND oral iron not an option
- ☐ Preventative (IV iron maintenance therapy dependant)
- ☐ Significant risk of hemorrhage AND low iron stores

2. PRIMARY CAUSE OF IRON DEFICIENCY +/- ANEMIA (not managed with oral iron)

Blood Loss
- ☐ Angiodysplasia
- ☐ Digestive tract blood loss (e.g. IBD, malignancy, ulcer)
- ☐ Menorrhagia

Iron Intake OR Requirement Change
- ☐ Decreased dietary intake
- ☐ Increased iron requirement (e.g. pregnancy)

Malabsorption
- ☐ Celiac
- ☐ Surgical (e.g. bariatric, gut resection)

Other
- ☐ Genetic (e.g. Hereditary Hemorrhagic Telangiectasia)
- ☐ _____

3. LAB MONITORING

Hemoglobin _____ g/L
Date: _____ MMM-DD-YYYY

PLUS ONE of the following tests (must be within 6 months)
- **Ferritin:** _____mcg/L **Date:** _____ MMM-DD-YYYY
- **Iron saturation:** _____ % **Date:** _____ MMM-DD-YYYY

SECTION B **Iron Therapy Protocol***

IRON SUCROSE IV THERAPY ORDER

SERIES MAXIMUM cumulative **DOSING = 1200 mg [exception for nephrologist MAX = 2400 mg]**
SERIES MAXIMUM cumulative **DURATION = 6 months [exception for nephrologist MAX = 12 months]**

☐ **Iron sucrose 200 mg IV every _____ x _____ doses**

IV Iron will be limited to a dose of 200 mg per infusion to maximize patient flow (clinic efficiency)

If you require an EXCEPTION to the DOSING PROTOCOL, please complete SECTION C (on page 2)

RESTRICTED TO BC Provincial Renal Agency Patients ONLY

☐ **Sodium ferric gluconate complex (FERRLECIT) 125 mg IV every _____ x _____ doses**

Prescriber last and first name, middle initial:	License #	Prescriber Signature:	Date:

SECTION C – EXCEPTION TO IRON DOSING PROTOCOL

PRESCRIBER

Summarize your reasons for an exception below:

Name: _____

DOB: _____

PHN: _____

Patient Phone _____

IV IRON ORDER

SECTION D – ADDITIONAL PRESCRIBER ORDERS / INSTRUCTIONS

Prescriber last and first name, middle initial: *(For orders in Section C or D)*	**License #**	**Prescriber Signature:**	**Date:**

SECTION E – BOOKING REQUEST To be completed by prescriber

Patient absences:_____

Patient **not available**: ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun

Preferred hospital for infusions:_____

PREGNANCY STATUS

☐ No

☐ Yes, greater than 17 weeks

☐ Yes, less than or equal to 17 weeks

SECTION F – ISLAND HEALTH BOOKING PERSONNEL COMPLETION ONLY

Location of infusions:

Date/ Time	Date/ Time	Date/ Time	Date/ Time
Date/ Time	Date/ Time	Date/ Time	Date/ Time

Expiration date of recurring encounter: _____ Patient Notified? _____

Additional Notes: