island health

Page 1 of 2

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, or this form will be returned.**

1. ORAL IRON (must be trialed before IV unless contraindicated)

Regimen Trialed: □ Ferrous fumarate 300mg PO daily or Q2Days □ Other _____

Reason for failure: _____

2. 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 Maintenance Therapy)
- ☐ Significant risk of hemorrhage AND low iron stores

PRIMARY CAUSE OF IRON DEFICIENCY +/- ANEMIA

- ☐ **Blood Loss**
- ☐ **Iron Intake OR Requirement Change**
- ☐ **Malabsorption**
- ☐ **Other:** _____

3. LAB MONITORING

Hemoglobin *(<110g/L):* _____ g/L

Date: _____ MMM-DD-YYYY

PLUS ONE of the following tests (must be within 6 months)

- **Ferritin** *(<30mcg/L):* _____mcg/L **Date:** _____ MMM-DD-YYYY
- **Iron saturation** *(<0.20)* **:** _____ **Date:** _____ MMM-DD-YYYY

(For Renal Patients, Iron Saturation <0.24)

SECTION B – EXCEPTION TO IRON DOSING PROTOCOL

B1. PRESCRIBER ORDER

B2. SUMMARIZE YOUR REASONS FOR EXCEPTION BELOW:

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

SECTION C **Iron Therapy Protocol***

Name: _____

DOB: _____

PHN: _____

Patient Phone _____

ACUTE IV IRON THERAPY TREATMENT ORDER

- ☐ **Preferred: Iron Isomaltoside 1000mg IV x 1 dose**
- ☐ **Iron sucrose 200 mg IV weekly x _____ doses**

SERIES **MAXIMUM** cumulative **DOSING** = *1200 mg* [exception for nephrologist MAX = 2400 mg]

SERIES **MAXIMUM** cumulative **DURATION** = *6 months* [exception for nephrologist MAX = 12 months]

MAINTENANCE IV IRON THERAPY TREATMENT ORDER

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

SERIES **MAXIMUM** cumulative **DOSING** = *1200 mg* [exception for nephrologist MAX = 2400 mg]

SERIES **MAXIMUM** cumulative **DURATION** = *6 months* [exception for nephrologist MAX = 12 months]

**** 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: *(For orders in Section C or D)*	**License #**	**Prescriber Signature:**	**Date:**

SECTION D– 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 E – 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: