Oshawa Clinic Group | Specialty Pharma Solutions

MONOFERRIC ORDER FORM

Patient Information

Patient Name:	DOB (dd/mm/yyyy):
Patient Address:	Patient Allergies:
Patient Contact Number(s):	HCN:
Patient Weight: Date:	Hemoglobin (g/dL): Date:

Prescriber Information

Prescribing Physician Name:	Prescribing Physician License #:
Prescriber Phone Number:	Prescriber Fax Number:

Primary Medication Order

☐ Hemoglobin >= 10 g/dL
- ☐ 500 mg (for patients < 50 kg)
- ☐ 1,000 mg (for patients 50 kg < 70 kg)
- ☐ 1,500 mg (for patients >= 70 kg)

☐ Hemoglobin < 10 g/dL
- ☐ 500 mg (for patients < 50 kg)
- ☐ 1,500 mg (for patients 50 kg < 70 kg) given in 2 divided doses of 1,000 mg + 500 mg (7 days apart)
- ☐ 2,000 mg (for patients >= 70 kg) given in 2 divided doses of 1,000 mg + 1,000 mg (7 days apart)

PRN & Pre-Medications

- ☐ Acetaminophen 325-650 mg PO PRN q 4-6 hours for pain, fever or chills
- ☐ Diphenhydramine 25-50 mg PO/IV PRN q 4-6 hours for itching, uticaria, puritis, hives
- ☐ Dimenhydrinate 25-50 mg PO/IV PRN q 4-6 hours for nausea and vomiting
- ☐ Hydrocortisone 100 mg IV PRN x 1 for anaphylactic reaction
- ☐ Epinephrine (1:1000) 0.01 mL/kg (max 0.5 mL) SC/IM PRN q 10-15 minutes x 2 for severe anaphylactic reaction
- ☐ Oxygen via mask/nasal prongs 2-5 L/min PRN for SOB or decreasing O_2 sat (below 90% if lower than baseline)
- ☐ Salbutamol 2 puffs q 4-6 hours via aerochamber PRN for dyspnea or wheezing
- ☐ Salbutamol 2.5 mg nebule for inhalation by nebulizer PRN for dyspnea or wheezing x 1 dose
- ☐ Other:

☐ LU Code 610 ☐ Coverage OHIP ☐ Other:

Frequency

☐ One-time infusion (no further infusions will be scheduled unless patient's dose must be split into 2 infusions).

☐ Administer # _____ infusions

At a frequency of:
- ☐ Weekly (one infusion every week)
- ☐ Every 2 weeks (one infusion every 2 weeks)
- ☐ Monthly (one infusion every month)

Clinic nurse will schedule additional appointments until they have been given x number of infusions at the ordered frequency.

Note: Prescribing physician responsible for ordering and monitoring patient blood work and notifying Oshawa Infusion Centre when patient no longer requires treatment.

Prescribing Physician Signature	DOB (dd/mm/yyyy):

Fax completed form to Oshawa Infusion Centre: 1-905-721-3494

Please note, there is a $100 sitting fee for each infusion.

RX MUST BE FILLED BY SPECIALTY PHARMA SOLUTIONS