

# Monoferric Patient Referral & Medical Order Form

## Patient Information

Last Name		First Name		Date of Birth (dd/mmm/yy) d   d   m   m   m   y   y		Health Card No.		Gender <input type="checkbox"/> M <input type="checkbox"/> F			
Street Number	Street Name			City/Town			Province		Postal Code		
Phone (Home)			Phone (Work)			Phone (Cell)			Email		
<input type="checkbox"/> Y <input type="checkbox"/> N Consent to leave message			<input type="checkbox"/> Y <input type="checkbox"/> N Consent to leave message			<input type="checkbox"/> Y <input type="checkbox"/> N Consent to leave message					
Diagnosis						Allergies					
CVAD (please submit protocol directive) <input type="checkbox"/> Portacath <input type="checkbox"/> PICC <input type="checkbox"/> N/A						Mobility Device <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> None					

## Physician Information

Physician Last Name		Physician First Name		Designation		Licence					
Street Number	Street Name			City/Town			Province		Postal Code		
Physician Office			Physician Fax			Physician Email			Preferred method of communication <input type="checkbox"/> Phone <input type="checkbox"/> Email		
Nurse Last Name		Nurse First Name		Nurse Phone							

## Medical Order

Medication Name						Body weight					
<b>Monoferric</b> (Iron Isomaltoside) 100mg/mL (1mL, 5mL, 10mL vials)						kg					
Dosage											
<b>Single Monoferric IV infusion up to 20 mg iron/kg body weight:</b>						<input type="checkbox"/> <b>Doses exceeding 20mg iron/kg body weight, OR exceeding 1500mg, must be split into two administrations, with an interval of at least one week:</b>					
<input type="checkbox"/> 1000 mg in 250mL NS or ____ mL NS IV over 30 mins.						Dose= ____ mg					
<input type="checkbox"/> Other: ____ mg in 250mL NS or ____ mL NS IV over ____ mins.						Week 1: ____ mg in ____ mL NS IV over ____ mins.					
<i>* If diluent, diluent volume, or infusion time, are not clearly stated on Order Form, product label administration guidelines, as per Product Monograph, will be followed.</i>						Week 2: ____ mg in ____ mL NS IV over ____ mins.					
Frequency				Number of doses				LU Code			

PRE-Medications

PRN Medications

- |   |  |
|---|--|
| <input checked="" type="checkbox"/> Acetaminophen 325-650 mg PO PRN q 4-6 hours for pain, fever or chills                                       | <input checked="" type="checkbox"/> Oxygen via mask/nasal prongs 2-5 L/min PRN for SOB or decreasing O2 sat (below 90% if lower than baseline) |
| <input checked="" type="checkbox"/> Diphenhydramine 25-50 mg PO/IV PRN q 4-6 hours for itching, urticaria, pruritis, hives                      | <input checked="" type="checkbox"/> Salbutamol 2 puffs q 4-6 hours via aerochamber PRN for dyspnea or wheezing                                 |
| <input checked="" type="checkbox"/> Dimenhydrinate 25-50 mg PO/IV PRN q 4-6 hours for nausea and vomiting                                       | <input checked="" type="checkbox"/> Salbutamol 2.5 mg nebule for inhalation by nebulizer PRN for dyspnea or wheezing x 1 dose                  |
| <input checked="" type="checkbox"/> Hydrocortisone 100 mg IV PRN x 1 for anaphylactic reaction  | <input type="checkbox"/> Other: _____  |
| <input checked="" type="checkbox"/> Epinephrine (1:1000) 0.01 mL/kg (max 0.5 mL) SC/IM PRN q 10-15 minutes x 2 for severe anaphylactic reaction |  |

## Special Instructions

If there is a variance in the patient's weight of more than 5 or 10% please contact me.

I would like a copy of the post-infusion reports

Please fax to:  Physician Fax  the following number:

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## Authorization

Physician Signature

X \_\_\_\_\_

Date (dd/mmm/yy)

d	d	m	m	m	y	y
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## Patient Consent

The Insight Health Program (the "Program") is provided by Insight Health Solutions. The Program offers certain patient support services which may include, as applicable, nursing services, injection and infusion of medication services, insurance reimbursement assistance and pharmacy services ("Services").

Insight Health Solutions reserves the right to modify or terminate the Program at any time without prior notice. Insight Health is committed to protecting patient confidentiality and patient health information, including without limitation personal information (name, address, contact details, date of birth, financial information) and health information (medical history and conditions, health insurance) (collectively, "Personal Health Information") in accordance with all applicable laws.

My healthcare provider has prescribed certain medication as identified above ("Product/s") for my use and has referred me to the Program. I have discussed the benefits and risks of use of the Product/s with my healthcare provider. By signing below, I acknowledge, understand and agree as follows:

- ✓ The Program shall collect, use, disclose and/or store (collectively, "Use") my Personal Health Information for the purpose of providing the Services, monitoring the Program, reporting adverse events or as may be required by applicable law.
- ✓ The Program may contact me by telephone or electronic mail using the contact information I have provided above, and I shall be responsible for any resulting telecommunication charges;
- ✓ My physician may provide this completed, signed Insight Health Care Patient Enrolment & Medical Order form to the Program;
- ✓ My insurance provider may disclose to the Program my insurance coverage information, and I consent to the Use by the Program of such information for the purpose of verifying coverage and otherwise arranging for reimbursement for the Product/s.
- ✓ The Program shall be my designated agent for purposes of assisting and selecting the pharmacy that will supply the Product and for purposes of forwarding the prescription, by fax or other mode of delivery, to the pharmacy chosen. This prescription represents the original of the prescription drug order and the receiving pharmacy is the only intended recipient and there are no others.
- ✓ My participation in this Program is voluntary, and I may withdraw this consent at any time by calling the Program at 905-813-4187 or by mail to Insight Health Solutions, Care Program at 2381 Bristol Circle, Unit 202, Oakville ON L6H 5S9. I further understand that withdrawal of my consent will end the use of my Personal Health Information by the Program and will result in termination of my participation in the Program and use of the Services.

Signature of Patient/Legal Representative

X \_\_\_\_\_

Printed Name of Patient/Legal Representative

\_\_\_\_\_

Date (dd/mmm/yy)

d	d	m	m	m	y	y
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Verbal Consent Obtained

Yes

Date (dd/mmm/yy)

d	d	m	m	m	y	y
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