insight health solutions
Trillium Health Partners

Fax or email completed form to:
905-829-4545 / insightWR@thp.ca

Monoferric Patient Referral & Medical Order Form

Patient Information

Last Name	First Name	Date of Birth (dd/mmm/yy)	Health Card No.	Gender
		d d m m m y y		☐ M ☐ F

Street Number	Street Name	City/Town	Province	Postal Code

Phone (Home)	Phone (Work)	Phone (Cell)	Email
☐ Y ☐ N Consent to leave message	☐ Y ☐ N Consent to leave message	☐ Y ☐ N Consent to leave message	

Diagnosis	Allergies

CVAD *(please submit protocol directive)* ☐ Portacath ☐ PICC ☐ N/A

Mobility Device ☐ Wheelchair ☐ Walker ☐ 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
			☐ Phone ☐ Email

Nurse Last Name	Nurse First Name	Nurse Phone	

Medical Order

Medication Name

Monoferric (Iron Isomaltoside) 100mg/mL (1mL, 5mL, 10mL vials)

Body weight ____ kg

Dosage

Single Monoferric IV infusion up to 20 mg iron/kg body weight:

☐ 1000 mg in 250mL NS or _____ mL NS IV over 30 mins.

☐ Other: _____ mg in 250mL NS or _____ mL NS IV over _____ mins.

**** 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.***

☐ **Doses exceeding 20mg iron/kg body weight, OR exceeding 1500mg, must be split into two administrations, with an interval of at least one week:**

Dose= _____ mg

Week 1: _____ mg in _____ mL NS IV over _____ mins.

Week 2: _____ mg in _____ mL NS IV over _____ mins.

Frequency _____	Number of doses _____	LU Code _____

PRE-Medications

PRN 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 02 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: _____

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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:

Authorization

Physician Signature

X _____

Date (dd/mmm/yy)
d d m m m y y

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

Verbal Consent Obtained

☐ Yes

Date (dd/mmm/yy)
d d m m m y y