

Patient Information

Last Name	First Name	Date of Birth (dd/mm/yy)	Health Card Number	Gender ☐ M ☐ F
Address (name/number)		Province	City/Town	Postal Code
Phone (Home)	Phone (Mobile)		Email	
Diagnosis			Allergies	
Medical History			Medications	

Physician Information

Last Name	First Name	Designation	Licence
Office Address (name/number)		Province	City/Town
Office Number		Fax Number	Email

Medical Order

Medication Name ☐ Monoferic (Iron Isomaltoside) 500ml – 1000mg ☐ Venofer (Intravenous Iron Sucrose) 100ml – 300mg	Weight (kg/lbs)	Height (ft)
PRN Medications (check to authorize) ☐ 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, urticaria, pruritis, hives ☐ Dimenhydrinate 25-50 mg PO/IV PRN q 4-6 hours for nausea and vomiting ☐ Epinephrine (1:1000) 0.01 mL/kg (max 0.5 mL) SC/IM PRN q 10-15 minutes x 2 for severe anaphylaxis		