Fax or email completed form to:
416-572-8747 / info@regen-iv.com

ReGenIV
Restore. Renew. ReGenIV.

REFERRAL & PRESCRIPTION FORM

Referral Date (DD/MM/YY):

PATIENT INFO		**PHYSICIAN INFO**
Patient Name:		Referring Physician:
Address:		CPSO:
		OHIP:
Date of Birth (DD/MM/YY)	Gender: M ○ F ○	Phone:
Phone:		Fax:
PHN:		

Medical Order

Note: Unless otherwise requested by the patient, this prescription will be directed to the on-site pharmacy at the patient's preferred ReGenIV Infusion clinic location and made available for pick-up upon arrival for the infusion appointment.

Body Weight: kg

Monoferric (Iron Isomaltoside) 100mg/mL IV (max dose 20mg/kg)

Infused as per Product Monograph administration guidelines

- ☐ **500 mg** (min weight 25kg)
- ☐ **1,000 mg** (min weight 50kg)
- ☐ **1,500 mg** (min weight 75kg)

LU Code

- ☐ LU Code 610

Pre-Medication *Reason:

- ☐ Methylprednisolone (Solu-medrol) 125mg IV
- ☐ Cetirizine 10mg PO

***Informed Consent Obtained (mandatory)**

- ☐ Informed Consent Obtained by referring prescribing physician

Physician Signature:

Date (dd/mm/yy):

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