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

Patient Name:

Address:

Date of Birth (DD/MM/YY)

Gender: M ○ F ○

Phone:

PHN:

PROVIDER INFO

Provider Name:

CPSO:

OHIP:

Phone:

Fax:

Medical Order

Infused as per Product Monograph administration guidelines

Body Weight: kg

Monoferric (ferric derisomaltose)
100mg/mL IV (max dose 20mg/kg)

- ☐ **500 mg** (Age 18+; Min Wt 25kg)
- ☐ **1,000 mg** (Age 18+; Min Wt 50kg)
- ☐ **1,500 mg** (Age 18+; Min Wt 75kg)

LU Code

- ☐ LU Code 610

Ferinject (ferric carboxymaltose)
50mg/mL IV (max dose 15mg/kg)

- ☐ **500 mg (Age 10+;** Min Wt 34kg)
- ☐ **1,000 mg** (Age 18+; Min Wt 67kg)

LU Code

- ☐ LU Code 735
- ☐ LU Code 736

Pre-Medication Considerations (select all that apply):

Indication: ☐ Hx of ≥2 drug allergies ☐ Asthma ☐ Prior mild hypersensitivity to IV iron ☐ Inflammatory Arthritis ☐ Other:

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

Signature:

Date (dd/mm/yy):

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