

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



REFERRAL & PRESCRIPTION FORM

BRITISH COLUMBIA

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: _____

College ID: _____

Phone: _____

Fax: _____

Medical Order

Infused as per Product Monograph administration guidelines

Body Weight: _____ kg

Monofer[®] (iron isomaltoside) **Age 18+**

100mg/mL IV (max dose 20mg/kg)

- ☐ 500 mg (Min Wt 25kg)
☐ 1,000 mg (Min Wt 50kg)
☐ 1,500 mg (Min Wt 75kg)

Ferinject[®] (ferric carboxymaltose)

50mg/mL IV (max dose 15mg/kg)

- ☐ 500 mg (**Age 12+**; Min Wt 34kg)
☐ 1,000 mg (Age 18+; Min Wt 67kg)

Is the patient covered by BC PharmaCare? ☐ Yes ☐ No

If yes: ☐ Special Authority form (HLTH 5818) completed and submitted to PharmaCare

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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