INFUSION HEALTHCARE
13 Eden Street, Newmarket
Phone: 0800 2 INFUSE (0800 2 463873)
Email: info@infusionhealthcare.nz
www.infusionhealthcare.nz

Please note this referral is for the administration of therapy only, this does not constitute a referral for investigation or other management.

PATIENT

NAME: _____ DOB: _____

PHONE: _____ NHI: _____

CLINICAL INFORMATION

ALLERGIES: _____

WEIGHT: _____ FERRITIN: _____ TSAT: _____ CRP: _____ Hb: _____

MEDICAL HISTORY: ☐ Pregnant (Gestation in weeks _____) ☐ Fluid Restriction ☐ Heart Failure ☐ Renal Failure

IRON ORDER

☐ Ferinject 500mg (1 vial)

☐ Ferinject 1000mg (2 vials)
DO NOT ADMINISTER MORE THAN 1000MG OF IRON PER WEEK.

☐ Ferinject 1500mg

☐ Ferinject 2000mg

Dose Calculator for Intravenous Iron

Hb g/L	Body weight 35 to <70kg	Body weight ≥ 70kg
<100	1500mg	2000mg
≥100	1000mg	1500mg

For patients with an Hb value ≥140 g/L, an initial dose of 500 mg iron should be given and iron parameters should be checked prior to repeat dosing.

REFERRING DOCTOR (Doctor's Signature essential for valid order)

NAME: _____ PROVIDER No. _____

ADDRESS: _____

DOCTOR'S SIGNATURE: _____ DATE: _____

ADMINISTERED BY INFUSION HEALTHCARE REGISTERED NURSE

NAME: _____ REGISTRATION NO: _____

SIGNATURE: _____ DATE: _____ TIME GIVEN: _____