

Priority Health Clinic – Iron Infusion Program

In association with Whole Health Pharmacy Pickering

100-1690 Dersan Street, Pickering, ON L1V 0G9

Phone: 905-686-8805 Fax: 1-855-493-3223

Email: info@priorityhealthclinic.ca



Patient Name (First and Last): _____

Date of Birth: _____ Gender: _____ Health Card #: _____

Address: _____

Phone Number: _____ Email Address: _____

Venofer (no LU code. Consider EAP if applicable)

Loading Dose: Iron sucrose 300mg IV every 2 weeks for 3 infusions (3 hour infusion time)

Maintenance: Iron sucrose 200mg IV once monthly PRN (1 hour infusion time)

Other: _____

Special instructions or comments: _____

Monoferric (LU 610)

Iron Isomaltoside: _____ mg IV (1 hour infusion time)

| Simplified Dosing Table: | | |
|--------------------------|---------------------------------|---------------------------------|
| Hb (g/dL) | Patient with body weight < 70kg | Patient with body weight > 70kg |
| > 10 | 1000 mg | 1500 mg |
| < 10 | 1500 mng | 2000 mg |

Special instructions or comments: _____

| | |
|---------------------------|--|
| Previous Medical History: | |
| Allergies: | |
| Medications: | |

Prescriber Name: _____ CPSO: _____ Billing #: _____

Phone Number: _____ Fax Number: _____

Signature: _____ Date: _____

**FAX FORMS TO PRIORITY HEALTH CLINIC AT 1-855-493-3223
PLEASE PROVIDE PATIENTS WITH PATIENT INFORMATION SHEET**

\$175.00 infusion fee applies for each infusion provided. Receipts will be provided.

For office use only:

Appointment Date: _____

Once booked fax this form to 289-731-2987