Order to Infuse – Ferric Derisomaltose

(DIN: 02477777) Order to Infuse for iron deficiency anemia

PerCuro by sentrex

t: 250-382-6270 | f: 250-382-6273

PATIENT PROFILE

Last Name: _____ First Name: _____

Phone: _____ Alternate: _____

DOB: (dd-mmm-yyyy) _____ PHN: _____ Sex: ○ Female ○ Male ○ Other

Address: _____ City: _____ Province: _____ Postal Code: _____

Caregiver Name (if applicable): _____ Caregiver Phone: _____

PHYSICIAN INFORMATION

Prescription for Ferric Derisomaltose (Select one below): **DIN: 02477777**

○ **1000mg IV over 30mins** ○ **1500mg IV over 45min** ○ **Other:** _____

PHYSICIAN STAMP

Mitte/Repeats: _____

Frequency: _____

○ **I authorize Monoferric to be administered postInfliximab infusion, following a 30mins normal saline flush 0.9%**

Last Name: _____ First Name: _____

Phone: _____ Fax: _____

I certify that this prescription is an original prescription and will not be reused.

Physician Signature: _____ Date: (dd-mmm-yyyy) _____

**Effective date, order expires one year from date of signature.*

Additional Physician Comments: