# INTRAVENOUS ORDER FORM
## Iron Infusion for Pregnancy

**Infusions are performed at Dermaluxe Injectables – 138 Shannon Avenue Geelong West, Vic 3218**

### PATIENT

NAME: ..... DOB: ..... PHONE: .....

### CLINICAL INFORMATION

**ALLERGIES:** .....

**WEIGHT:** **Hb:** **FERRITIN:**

**Medical History:** ☐ Pregnant (Gestation in weeks .....) ☐ Fluid Restriction ☐ Heart Failure ☐ Renal Failure

**** PLEASE ISSUE A VALID SCRIPT TO PATIENT FOR ALL REQUESTED DRUGS ****

### IRON ORDER (Pregnant women MUST be beyond 16 weeks gestation)

- ☐ **Ferinject 500mg** (1 vial)
- ☐ **Ferinject 1g** (2 vials)
- ☐ **Monofer 500mg** (1 vial)
- ☐ **Monofer 1g** (1 x 1000mg vial)
- ☐ **Monofer 1.5g** (3 x 500mg vials, ***single dose***)

Post infusion flush of Normal Saline 100mls

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### CONSENT *(Patient MUST sign this consent in the presence of the referring doctor)*

My medical practitioner and I have discussed my present condition(s) and the various ways in which it may be treated, including the above proposed procedure and/or treatment. The doctor has informed me, and I understand:

- The procedure/treatment proposed
- The procedure/treatment carries some risks, and complications may occur, and
- Additional treatments may be needed to achieve the desired results

I understand that I may withdraw my consent. **I request and consent** to the procedure/treatment described above for me.

**PATIENT'S SIGNATURE:** ..... **DATE:** .....

### REFERRING DOCTOR (Drs Signature essential for valid order)

NAME: ..... PROVIDER No. .....

ADDRESS: .....

DOCTOR'S SIGNATURE: ..... DATE: .....

**Please complete and return this form to:**
**admin@themidwiferycentre.com.au**
**Patient will be contacted directly to book once referral is received**
**Patient MUST fill script prior to appointment and bring all MEDICATION to the clinic for infusion.**
**IV Fluid (Saline and Hartmanns) supplied.**