



Name: _____

Date of Birth: DD / MM / YYYY _____

MRN Number: _____

NHS Number: _____

(OR AFFIX HOSPITAL LABEL HERE)

Parenteral Iron Chart

DRUG AND FOOD ALLERGIES AND SIGNIFICANT ALERTS			
Date	Drug/Food	Reaction Details	Sign
(If NIL KNOWN tick here, & date & sig) <input type="checkbox"/>			
To be completed by nurse/prescriber/ward nurse/ pharmacy staff			

The following **MUST** be completed

Date	Weight (kg)	
Height (cm)	Haemoglobin (g/L)	
Consultant	Speciality	Ward/Department

Parenteral Iron Infusion:

Patients must be observed for adverse effects for at least 30 minutes following each infusion.

CONTRAINDICATIONS	PROCEED WITH CAUTION
<ul style="list-style-type: none"> Hypersensitivity to parenteral iron Non-iron deficiency anaemia Iron overload or disturbances in utilization of iron Decompensated liver cirrhosis and hepatitis Acute or chronic infection 	<p>Increased risk of hypersensitivity reactions in patients with immune or inflammatory conditions i.e. asthma, rheumatoid arthritis, and atopic allergy.</p>

Ferinject® (ferric carboxymaltose) Dose								
Hb (g/L)	35-39kg	40-49kg	50-59kg	60-69kg	70-79kg	80-89kg	90-99kg	>100kg
<100	700mg	800mg	1,000mg	1,000mg + 500mg*	1,000mg + 1,000mg*	1,000mg + 1,000mg*	1,000mg + 1,000mg*	1,000mg + 1,000mg*
>100	700mg	800mg	1,000mg	1,000mg	1,000mg + 500mg*	1,000mg + 500mg*	1,000mg + 500mg*	1,000mg + 500mg*

*Second dose to be given at least 7 days after the first dose.
A single Ferinject® infusion should not exceed either:

- 20mg/kg, or
- 1,000 mg (max. dose is 1,000 mg per week)

Dilute in 250ml sodium chloride 0.9%. Administration rate = minimum 15 minutes.

Monofer® (ferric derisomaltose) Dose								
Hb (g/L)	35-39kg	40-49kg	50-59kg	60-69kg	70-79kg	80-89kg	90-99kg	>100kg
<100	700mg	800mg	1,000mg	1,200mg	1,400mg	1,600mg	1,800mg	2,000mg
>100	700mg	800mg	1,000mg	1,000mg	1,400mg	1,500mg	1,500mg	1,500mg

A single infusion should not exceed 20mg/kg. Dilute in 250ml sodium chloride 0.9%.
Administration rate:

- Doses up to 1,000 mg = minimum 15 minutes
- Doses exceeding 1,000 mg = minimum 30 minutes

Prescribe parenteral iron here:

Date	Approved name	Dose	Route	Additional instructions/ Indication	Signature/ Bleep	Given by/ Time	Pharmacy

PRESCRIPTION CHART VALID FOR 6 MONTHS ONLY

As Required Drugs (prescriber to sign all that apply)

Drug			Approved name Please print			Date	Time	Dose	Sig	Date	Time	Dose	Sig
PARACETAMOL								Route				Route	
Dose PRN	Max Frequency	Additional Instructions											
500mg - 1g	4 Hourly Max. 4g/24hrs		For Mild Infusion Reaction										
	Route												
	PO/IV												
Start Date	Signature		Bleep										
Pharmacy Use													

Drug			Approved name Please print			Date	Time	Dose	Sig	Date	Time	Dose	Sig
CHLORPHENAMINE								Route				Route	
Dose PRN	Max Frequency	Additional Instructions											
4mg	QDS		For Mild Infusion Reaction										
	Route												
	PO												
Start Date	Signature		Bleep										
Pharmacy Use													

Drug			Approved name Please print			Date	Time	Dose	Sig	Date	Time	Dose	Sig
CHLORPHENAMINE								Route				Route	
Dose PRN	Max Frequency	Additional Instructions											
5 - 10mg	STAT		For Moderate Infusion Reaction										
	Route												
	IV												
Start Date	Signature		Bleep										
Pharmacy Use													

Drug			Approved name Please print			Date	Time	Dose	Sig	Date	Time	Dose	Sig
HYDROCORTISONE								Route				Route	
Dose PRN	Max Frequency	Additional Instructions											
100mg	STAT		For Infusion Reaction										
	Route												
	IV												
Start Date	Signature		Bleep										
Pharmacy Use													

Drug			Approved name Please print			Date	Time	Dose	Sig	Date	Time	Dose	Sig
SODIUM CHLORIDE 0.9% FLUSH								Route				Route	
FOR PERIPHERAL VENOUS CANNULA (PVC)													
Dose	Max Frequency	Additional Instructions											
3-5ml	STAT		As per PGD or patient protocol										
5-10mL to test patency of newly inserted PVC	Route												
	IV												