305-1120 Yates Street
Victoria BC V8V 3M9
Phone: 250 382 6270
Fax: 250 382 6273

PerCuro Clinical Research

STEPS:
1. Complete all sections of form
2. **Fax** completed form to PerCuro Clinics at **250 382 6273**

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

Patient Profile		
Last name:	First name:	Patient DOB dd/mmm/yyyy:
Phone:	Alternate:	Sex: ☐ M ☐ F ☐ Other
PHN:		
Caregiver (if applicable):	Name:	Phone:
Address:		
City:	Province:	Postal Code:

Physician Information

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

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

Physician Stamp	**Mitte/Repeats**
	☐ **I authorize Monoferric to be administered post Infliximab 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:	