P R O V I S

Provis Patient No.

MEDICATION ORDER FORM

IRON ISOMALTOSIDE
(Monoferric®)

Patient's Surname	**Given Name & Initials**	**Date of birth** ______ / ______ / __________ dd mm yyyy
Referring MD/Oncologist		

Patient's Height: __________ cm Weight: __________ kg BSA: ____________ m^2	Cycle: ___________________
Pre-Medication ☐	☐ Other :……………………………………………………

☐ **Iron Isomaltoside 1000 mg in 250mL NS infused over 30 minutes**

Or

☐ **Iron Isomaltoside …….. mg in …….. mL NS infused over 20 minutes to 30 minutes**

Scheduled Frequency: ☐ **Cycles q 28 days**

Or

☐ **Cycles q …… days**

(For Provis Use Only)

Tx 1: _________________________ Tx 2:______________________

Physician's Signature (Referring Physician)	______ / ______ / __________ dd mm yyyy
Signature of Provis Physician	______ / ______ / __________ dd mm yyyy

Repeat Order:

Provis requires a new medication order for each 2 treatments.

Fax completed form to: 416-532-3635

CL Medication Order Form Monoferric 2019-04-30
July 2012
Revised: