Ferric Carboxymaltose (Ferinject) Infusion

Checklist

	CHECK LIST	RESPONSE
1.	Baseline Measurements: Weight…….Kg Phosphate……mmol/L Hb……g/L. Ferritin……. ug/L	
2.	Is the patient antenatal, postnatal or neither. If antenatal, number of week pregnant …….. (NB IV Ferric Carboxymaltose infusion **contraindicated in first trimester**)	☐ Antenatal ☐ Postnatal ☐ Neither
3.	Does the patient meet the criteria for IV iron infusion in the POAC clinical guideline?	Yes / No
4.	Have contraindications been excluded? (See POAC guideline)	Yes / No
5.	Has funded Ferinject infusion been authorised by POAC (see application form)	Yes / No
6.	Is phosphate >/= 0.8 mmol/L? If not, defer infusion until phosphate normal.	Yes / No
7.	Has patient been informed of potential adverse effects?	Yes / No
8.	Have the patient's questions been answered after they have read the Ferinject Patient Information Sheet?	Yes / No
9.	Has the patient signed the consent form?	Yes / No
10.	Has dose of Ferric Carboxymaltose been calculated using an approved method based on patient's weight and Hb? (Refer to POAC guideline). IF MORE THAN 1000MG DOSE REQUIRED ADMINISTER SECOND DOSE AT LEAST SEVEN DAYS (ONE WEEK) AFTER THE FIRST DOSE	Yes / No

Ferric Carboxymaltose (Ferinject) Infusion

Patient Consent

Procedure

Intravenous infusion of Ferric carboxymaltose (Ferinject) over at least 15 minutes for Iron Deficiency Anaemia.

Consent

I _____ (first name)

_____ (last name)

Date of birth: _____

- Have had explained to me the purpose and procedure of Ferric carboxymaltose (Ferinject) by intravenous infusion.
- I confirm that I have had explained to me adverse effects
- Have been provided with, or informed where to find electronic version of the Ferinject Patient Information Leaflet

Signature: _____

Date: _____