Ferric Carboxymaltose (Ferinject) Infusion

Checklist and Patient Consent — POAC

Last updated: October 2026

1. Baseline Measurements

Age (yrs):			

⚠️ **Note: If patient is under 14 years of age, endorsement required from paediatric haematologist.**

Weight (kg):	**Hb (g/L):**	**Ferritin (µg/L):**	**Phosphate (mmol/L):**

⚠️ **Note:** If pregnant, fetal heart monitoring is not routinely required. If clinical concerns and is available, consider monitoring **pre and post infusion as per HealthPathway advice.**

2. Pregnancy Status

Is the patient antenatal, postnatal or neither?	☐ Antenatal ☐ Postnatal ☐ Neither
If antenatal, number of weeks pregnant:	

⚠️ **Note: There is no efficacy and safety data on the use of Ferinject in the first trimester. Proceed only where discussed with and endorsed by specialist obstetrician.**

3. Clinical Checklist

⚠️ **Note: POAC funds a maximum of 1000mg. Further dosing only funded following repeat blood tests.**

#	CHECK	RESPONSE
1	Does the patient meet the criteria for IV iron infusion in the HealthPathway?	☐ Yes ☐ No
2	Have contraindications been excluded?	☐ Yes ☐ No
3	**Important!** Have you checked recommendations and tested phosphate if recommended? Refer to HealthPathway for guidance. If phosphate lower than 0.8 mmol/L, defer infusion until phosphate normal.	☐ Yes ☐ No ☐ NA
4	Have you **CONFIRMED** that the patient has not been prescribed and had an infusion since the last laboratory tests were completed?	☐ Yes ☐ No
5	Has patient been informed of potential adverse effects, including that IV ferric carboxymaltose **has been shown to impair bone formation, cause osteomalacia, and increase fracture risk even after a single dose**?	☐ Yes ☐ No
6	Have the patient's questions been answered after they have read the Ferinject Patient Information Sheet?	☐ Yes ☐ No
7	If patient <35kg has the dose of Ferric Carboxymaltose been calculated using an approved method based on patient's weight and Hb? Refer to HealthPathway for dose calculation. All patients ≥ 35 kg receive 1000mg as a single dose.	☐ Yes ☐ No ☐ NA

Patient Consent

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

First name: _____ Last name: _____ Date of birth: _____

I (the patient, or the person signing on their behalf) confirm that:

☐ I have had explained to me the purpose and procedure of Ferric carboxymaltose (Ferinject) by intravenous infusion.

☐ I have had explained to me adverse effects, including that IV ferric carboxymaltose has been shown to impair bone formation, cause osteomalacia, and increase fracture risk even after a single dose.

☐ I have been provided with, or informed where to find, an electronic version of the Ferinject Patient Information Leaflet.

☐ If signing on behalf of the patient: I am the patient's parent, legal guardian, or attorney under an Enduring Power of Attorney (EPOA) for personal care and welfare, and am legally authorised to consent to this treatment on their behalf.

Consent given by: ☐ Patient ☐ On behalf of the patient

Name of person signing (if not the patient): _____

Relationship / authority: ☐ Parent ☐ Legal guardian ☐ EPOA (personal care and welfare) ☐ Other: _____

Signature: _____ Date: _____