

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)	<input type="checkbox"/> Antenatal <input type="checkbox"/> Postnatal <input type="checkbox"/> Neither
3.	Does the patient meet the criteria for IV iron infusion in the POAC clinical guideline OR has the request come directly from specialist	Yes / No
4.	Have contraindications been excluded? (See Auckland Regional Healthpathway)	Yes / No
5.	Has funded Ferinject infusion been requested or authorised by POAC and a funding voucher provided? If no, contact POAC for approval or see application form)	Yes / No
6.	Is phosphate ≥ 0.8 mmol/L? <u>Check if testing required*</u> 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.	Is this a Renal patient with a fistula? If yes, which arm LEFT / RIGHT (Do not use the LEFT/RIGHT arm for any procedures)	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 Auckland Regional HealthPathway). DO NOT ADMINISTER MORE THAN 1000mg PER WEEK	Yes / No

* Check phosphate level if: the patient has had ≥ 2 iron infusions in the preceding 6 months; or the patient is at risk of hypophosphataemia e.g. BMI < 18, poor nutrition, chronic diarrhoea.

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: _____

Doctor Name: _____

Doctor Signature: _____

Date: _____

Nurse Name: _____

Nurse Signature: _____

Date: _____