

Ferinject infusion Patient Consent Form

Patient Name: _____

D.O.B: _____

Date: _____

I understand and accept that this procedure involves insertion of an IV cannula and will require me to remain for 15mins after the procedure has been completed. Please allow at least 1 hour for this appointment.

Please understand that appointment times are limited. If you must cancel your appointment, we respectfully request 24 hours notice. Missed appointments, or appointments cancelled without the 24 hour notice, may incur a fee of \$108.00 (50% of fee) which will be charged to your payment details provided to us when booking.

Contra-indications for an Iron Infusion:

Regnant - First Trimester Y ☐ N ☐

Known hypersensitivities to Iron Y ☐ N ☐

Anaemia not due to Iron deficiency Y ☐ N ☐

Hemochromatosis Y ☐ N ☐ Uncontrolled

hyperparathyroidism Y ☐ N ☐

Inflamed Tissues/Ulcers/Infection Y ☐ N ☐

CONSENT:

I hereby acknowledge that this procedure has been explained to me including possible side effects and risks associated with the procedure, which may include:

- o nausea, abdominal pain, constipation, diarrhoea, vomiting
- o headache
- o dizziness
- o tachycardia and hypertension or hypotension
- o injection site reactions
- o skin staining at site: Leakage of Ferinject at the injection site may lead to long lasting or permanent brown discolouration.
- o rare severe anaphylaxis reactions

I acknowledge that my treating doctor has the appropriate expertise and experience to perform this procedure, and that despite all due professional care and responsibility, it is possible that the anticipated result may not be achieved and complications may occur.

I have had the opportunity to ask questions about the above procedure and I am satisfied I understand the information I have received. I hereby consent to this procedure and the costs detailed.

	Item Numbers	Fee
Iron Infusion Fee	23	\$215.00
Less Expected rebate		\$43.90
Out of pocket costs		\$171.10
	Please note: the Iron needs to be purchased from the pharmacy prior to your administration appt. The Doctor will write a script at your first appt.	Your standard PBS script fee at the Pharmacy.
Non cancellation fee		\$108.00

I understand and consent to the costs incurred by this procedure.

Signed by patient:

_____ Todays Date: _____

Doctor:

_____ Todays Date: _____

Observations:

	Temp	HR	BP
Baseline			
5 min			
10 min			
20 min			
Prior to discharge			