BANNOCKBURN SURGERY

FERINJECT CONSENT

<PtTitle> <PtFirstName> <PtSurname>
DOB: <PtDoB> Age: <PtAge>
<PtStreet>, <PtCity>, <PtPostcode>.
<PtMCNo>/<PtMCLine>
Tel. <PtPhoneH> Mob. <PtPhoneMob>

INTRAVENOUS IRON REPLACEMENT THERAPY

Your doctor has recommended an intravenous iron infusion (FERINJECT) for the treatment of your iron deficiency.

When making your booking please advise reception staff that you require an "appointment for an iron infusion". This enables an appropriate time to be made when the treating doctor, nurse and treatment room are concurrently available. Please be aware that the procedure may take up to an hour.

Please take your script to the pharmacy in advance to ensure the medication is available in time for your appointment. You need to bring the medication with you on the day as the clinic does not have this medication in stock.

Estimated Fee	Materials Fee (Inc GST)	Estimated Out of Pocket Fee
Up $180	$22	Up to $100

INFORMED CONSENT TO RECEIVE INTRAVENOUS IRON REPLACEMENT THERAPY

While every effort will be made to ensure the health and safety of the patient during and post the infusion, adverse side effects may occur. Administration of FERINJECT comes with risks including but not limited to:

- Anaphylactic reaction (rare)
- Paravenous leakage - leakage of Ferinject at the injection site may potentially lead to brown discolouration and irritation of the skin (uncommon)
- Neurological disorders e.g headaches and dizziness (common)
- Vascular disorders e.g. tachycardia, hypertension, hypotension, flushing (uncommon)
- Gastrointestinal disorders e.g. nausea, vomiting, abdominal pain, constipation, diarrhoea (common)
- Skin disorders e.g. skin irritation, rash (common)
- Musculoskeletal disorders e.g. myalgia, arthralgia (uncommon)

Minor reactions from Ferinject can occur up to 48 hours post infusion.

CONFIRMATION by Doctor
I, Doctor .<DrName>*(name of doctor)*

Signature of Doctor..... Date: .....

PATIENT'S SIGNATURE
*(*if patient or parent/guardian consenting to treatment please state relationship to patient ……..)*

I hereby confirm that I consent to the Ferinject Intravenous Iron Replacement Therapy

Full name……

Signature of Patient ..... Date: .....