

Ferinject® Patient Consent Form



Patient Name: _____

Date: _____

Address: _____

D.O.B: _____

Part 1 Does the patient have capacity? ☐ Yes

☐ No → Complete Part 1

Follow the Advance Care Directive (ACD), or obtain consent from legal substitute medical treatment decision maker (MTDM). Name of substitute: _____

Category: _____

Part 2 Is interpreter required? ☐ No ☐ Yes (Language) _____ → Complete Part 2

☐ In-person ☐ Telephone Interpreter Name: _____ Sign (if in-person) _____

Part 3 Patient OR MTDM requests the Iron infusion (Ferinject®).

Extraordinary patient-specific issues (in having or NOT having infusion) and **alternative** treatment options discussed: _____

Part 4 Clinical Details

☐ **Prolia** Last date: _____ (Ideally 3/12) ☐ Heart Failure ☐ Kidney or Liver disease

Today's **Weight** _____ kg

Ferritin _____ micrograms/L **Hb** _____ g/L (test date _____) **Max 500mg dose if Hb ≥ 140.**

Ferinject dose _____ mg Calculations: ☐ Simple = _____ mg ☐ Ganzoni
_____ mg

Follow-up: Blood test/s: (weeks post) _____

Calcium/Phosphate check ordered for: _____ ☐ Pathology request/s given to patient

Restart oral iron ☐ No or N/A ☐ Yes from: _____ (Not within 5 days)

Skin staining Images



Mild⁽¹⁾



Moderate⁽²⁾

Extensive⁽³⁾

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Part 5 Costs for Ferinject® procedure

Fee payable for all patients is \$316 per infusion including a \$100 deposit required at the time of booking. Prescription cost for Ferinject is not included. Where total dose exceeds 1gram this requires 2 infusions at least a week apart. The same total fee applies for second infusion.

Part 6

I acknowledge that the doctor has explained the “Iron infusion” information brochure including:

- Iron deficiency anaemia, benefits of iron replacement treatment, and the options available including Ferinject®. More than 1 infusion and/or additional treatment may be required.
- Possible risks in not having Ferinject® Including ongoing tiredness, worsening anaemia.
- General/specific risks of Ferinject® including possible side effects:
 - Feeling sick or vomiting,
 - Temporary metallic taste changes , headache, muscle or joint pain, low blood phosphate.
 - Blood pressure changes, shortness of breath, itchy skin or rash
 - Uncommon, but possible risk of **long lasting or permanent brown skin discolouration** called iron staining and the possible severity (Refer colour images p3).
 - Rare risk of serious allergic reaction called anaphylaxis, which can be life threatening.
 - Risks with any current/possible infection, or if pregnant (tell doctor if pregnant / trying)
 - Complication risk if given within 3 months of a Denosumab (Prolia) injection
- If a life-threatening event occurs during the procedure, treatment will be based on any documented discussions such as an advance care directive (ACD)
- I understand and agree to immediately notify the nurse or doctor present during the procedure if I have **any** reactions, concerns or discomfort / swelling or pain at the needle (drip) site.
- I understand the out-of-pocket costs and know that a doctor/nurse other than the consenting doctor is likely to administer therapy and provide appropriate treatment on the day of infusion.
- I was able to ask questions and raise concerns with the doctor.

If I choose not to consent, it will not negatively affect my access, outcome or rights to medical treatment in any way. I understand I have the right to change my mind (withdraw consent) at any time, including after signing this form (this should be in consultation with the doctor/clinician).

I / MTDM have received the consumer information booklet titled “Iron infusion”. Informed (as above), I consent to having the Ferinject® iron infusion therapy.

Patient:

D.O.B:

Patient signature:

or MTDM Name:

MTDM Signature:

Doctor: Signature:

Date: