INFORMED CONSENT FOR INTRAVENOUS IRON REPLACEMENT THERAPY

**FERINJECT INFUSION**

INDICATION:

* Intravenous iron infusion might be indicated if you suffer from iron deficiency anaemia where you have been unable to tolerate oral supplementation, or where oral supplementation has failed to improve your iron store
* The cause of the iron deficiency needs to be investigated

CONTRAINDICATIONS:

* Please notify the nurse or doctor caring for you if any of the following apply to you:
  + Known allergy to FERINJECT
  + Liver dysfunction
  + Acute infection
  + Pregnancy in the first trimester
  + Iron overload
  + Anaemia not caused by iron deficiency
  + Under 14 years of age

POSSIBLE ADVERSE REACTIONS:

* Headache, dizziness
* Skin irritations such as rash, hives or itch
* Hypertension
* Nausea
* Injection site reaction
* Low phosphate levels
* Muscle and joint aches and pains

UNCOMMON ADVERSE REACTIONS:

* Leakage of FERINJECT at injection site may lead to long-lasting brown discolouration of the skin
* Anaphylaxis to FERINJECT is potentially life-threatening, but RARE
  + I have viewed and understand the photos displaying uncommon adverse reactions

NAME OF PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree to have the FERINJECT infusion entirely at my own risk. I understand the list of possible adverse reactions. In the event of an emergency or anaphylactic reaction, I give the staff at Hunter’s Hill Medical Practice authority to administer all necessary first aid or resuscitation measures, and transfer to hospital via ambulance and alert my next of kin.

Signature of patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_