RX
Physician:____________
Address:__________
Phone:___________
Fax:_____________

Re Patient: ______________
Address:____________
PHIN: _______________ DOB:________
Phone:_____________

1) New Rx
MONOFERRIC IRON

Sig: Administer by IV Infusion as directed per protocal

500 mg ___

1000 mg ___

1500 mg ___

2000 mg ___

Refills:_____

Physician Signature: ______________ *Date:_________________*