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Frequent Hemodialysis Network
MONTHLY IV IRON THERAPY FORM #203

Instructions:

Review patient medication records for **monthly** IV Iron use. Record only intravenous (IV) iron on this form.

For EPO and other injectable medications, use Form 204.

For all other medications, over-the-counter meds, and supplements, use Form 205. Oral (po) iron should also be recorded on Form 205.

Schedule for form completion: For both daily and nocturnal studies, this form is completed at baseline and monthly during follow-up.

1. Participant ID #	2. Alpha Code	3a. Visit Type	3b. Visit Number	4. Visit Date: dd/mon/yyyy

5. Has the participant used any IV Iron during the last **1** month? .....__
   0=No, skip to question 200.
   1=Yes, complete Table 1

TOTAL IV IRON USE FOR ONE MONTH

IV Iron Medication Name	Medication Code*	Route of Admini-stration 0=Not IV 1=IV	Number of *times* given during month being reported	TOTAL *milligrams* given during month being reported
6.		__	__ __	__ __ __ __

*The medication code is electronically found on the code list accessed during data entry.

200. Date this form completed (dd/mon/yyyy)..... __ __/__ __ __ /__ __ __ __

201. Username of person reviewing completeness of this form..... __ __ __ __ __ __ __

For Clinical Center Use Only:

202. Username of person entering this form: __ __ __ __ __ __ __

203. Date entered: (dd/mon/yyyy) __ __/__ __ __ /__ __ __ __