Anara Infusion & Wellness Group
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IRON INFUSION SERVICE REQUISITION

PATIENT INFORMATION (attach patient label)

Patient Name:	M☐ F☐	Referral Date:_____
ULI:	DOB:	Current Patient Weight: _____
Address:	Postal Code:	Date Weight Recorded: _____
City/Province:	Home phone:	
Email:		

☐ Patient has had recent blood work* completed ***within 3 weeks*** and requires infusion based on results *Please include in the notes*: Ferritin, Iron*/TIBC (if ferritin 30-100), *Hgb/MCV le* vels
☐ Infusion indication (MUST provide additional clinical details based on above):

PATIENT HISTORY

☐ Patient has ***no known*** drug allergies
☐ Patient is allergic to: _____ with a reaction of _____
☐ Patient has had an iron infusion in the past

☐ ***KNOWN*** adverse reaction to infusion (provide details below)

☐ Patient is pregnant
☐ If oral iron therapy has ***NOT*** been attempted, please provide a detailed reason below.

Relevant Medical History & Notes:

PRESCRIPTION

☐ VENOFER Infusion
Iron Sucrose _____mg by IV infusion x_____ refills - titrated to normal Hgb ranges
** Note: *Any refills requested require a standing lab requisition attached to this referral***

☐ Monoferric Infusion
Ferric Derisomaltose_____mg by IV infusion as per fixed dosing schedule (for patients > 50kg)
(For patients weighing < 50kg, a dose of **20mg/kg** will be used)

☐ Consent Given for Pharmacist Prescription Selection
Pharmacist will select from either of the above options based on individual patient coverage/insurance needs.

Patient Pharmacy:

REFERRING PHYSICIAN/ NURSE PRACTITIONER INFORMATION
Referring Clinic:_____
Phone:_____Fax:_____
Physican/Nurse Practitioner Name:_____
PRAC ID#:_____

Referring Physician/ Nurse Practitioner Signature: