



Anara Infusion & Wellness Group  
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### IRON INFUSION SERVICE REQUISITION

#### PATIENT INFORMATION (attach patient label)

Patient Name: \_\_\_\_\_

ULI: \_\_\_\_\_

Address: \_\_\_\_\_

City/Province: \_\_\_\_\_

Email: \_\_\_\_\_

M ☐ F ☐

DOB: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Home phone: \_\_\_\_\_

Referral Date: \_\_\_\_\_

Current Patient Weight: \_\_\_\_\_

Date Weight Recorded: \_\_\_\_\_

- ☐ Patient has had recent blood work\* completed **within 3** months and requires infusion based on results \*Please include in the notes: *Ferritin, Iron/TIBC* (if ferritin is 30-100), *Hgb/MCV* levels.
- ☐ 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

- ☐ VENOFRER 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)

- ☐ I hereby authorize Anara Infusion & Wellness Group to transmit the above prescription to the pharmacy of choice for medication preparation and dispensing.

Patient Pharmacy: \_\_\_\_\_

#### REFERRING PHYSICIAN/NURSE PRACTITIONER/ MIDWIFE INFORMATION

Referring Clinic: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Physician/Nurse Practitioner Name: \_\_\_\_\_

PRAC ID#: \_\_\_\_\_

Referring Physician/ Nurse Practitioner / M i d w i f e Signature: \_\_\_\_\_