



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** 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

VENOFEER 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: