Anara Infusion & Wellness Group
Suite #340 180 Quarry Park Blvd SE
Calgary, AB T2C3G3
Ph: (403) 222-0741 Fx: 1(587) 318-2736
email: zenaida@anarainfusion.com

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

□ 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)

□ 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:_____
Physican/Nurse Practitioner Name:_____
PRAC ID#:_____

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