C·infuse is now WELL Health | DIAGNOSTIC CENTRES

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# IRON INFUSION SERVICE REQUISITION

**PATIENT INFORMATION** (attach patient label)

Patient Name: ☐M ☐F
ULI: DOB:
Address: Postal Code:
City, Province: Home phone:
Email:

Referral Date: _____

**Current** Patient Weight: _____

Date Weight Recorded: _____

☐ Patient has had relevant bloodwork* completed ***within 3 weeks*** and requires infusion based on results
* Includes: *CBC, Ferritin, Iron Panel (Serum Iron, TIBC, T-Sat), Hgb/MCV*

☐ 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 reactions 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:

☐ VENOFER Infusion

Iron Sucrose **300 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

Iron Isomaltoside **1000 mg** (for patients ≥50kg) by IV infusion as per fixed dosing schedule
(For patients weighing < 50 kg, a dose of **20 mg/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.

**REFERRING PHYSICIAN INFORMATION**
Referring Clinic: _____
Phone: _____ Fax: _____
Physician Name: _____
PRAC ID#: _____

Referring Physician Signature: