

REQUEST FOR EXAMINATION – CALGARY IRON INFUSION

PATIENT INFORMATION (attach patient label)

Patient Name: _____	<input type="checkbox"/> M <input type="checkbox"/> 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:

VENOFR 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: