C-infuse (a C-health program)
Suite 210, 1016 - 68 Avenue SW
Calgary, AB T2V 4J2
Ph: (403) 541-0033 Fx: (403) 541-0032
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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: