



Patient information

Patient Name: _____ Date of Birth (dd/mm/yyyy): _____

Phone Number: _____ PHN: _____ Email Address: _____

Current Address: _____

Indication

Iron deficiency +/- anemia requiring parenteral iron

Prescription

Monoferric (iron isomaltoside) 500mg IV bolus Monoferric 1000 mg IV bolus

Venofer (iron sucrose) _____ mg x _____ infusions. Give all doses within 14 days 28 days other: _____

Additional instructions _____

Other: _____

Delivery: Pick up at pharmacy Delivery to Wellspring

Three locations to serve you:

Wellspring Vancouver
510-943 West Broadway
Please fax to Wellspring Infusion Clinic at
604-239-5050
This prescription will be filled by
Wellness Pharmacy located at
109- 805 West Broadway, Vancouver

Wellspring Surrey
106-12565 88 Avenue
Please fax to Wellspring Infusion Clinic at
604-239-5050
This prescription will be filled by
NAZ's Pharmacy located at
101-12565 88 Ave, Surrey

Wellspring Abbotsford
102-2180 Gladwin Road
Please fax to Wellspring Infusion Clinic at
604-239-5050
This prescription will be filled by
Wellness Pharmacy located at
102-2180 Gladwin Road, Abbotsford

Payment Information

Has "Special Authorization" been applied for? Yes No

Does the patient have private insurance? Yes No

Lab Work

Please attach the most recent relevant lab work or provide the following:

Hgb: _____ Date: _____

Ferritin: _____ Date: _____

Transferrin Saturation: _____ Date: _____

Relevant Patient Information

Patient weight (required to calculate appropriate dosage): _____

Has the patient experienced an allergic reaction to iron infusion in the past? Yes No

If yes: give methylprednisolone 125mg IV and famotidine 10mg IV 30 minutes prior to infusion

If yes, please specify reaction: _____

Does the patient have asthma, severe eczema, or multiple drug allergies? Yes No

If yes: give methylprednisolone 125mg IV and famotidine 10mg IV 30 minutes prior to infusion

If yes, please specify reaction: _____

Does the patient have inflammatory arthritis? Yes No

If yes: give methylprednisolone 125mg IV 30 minutes prior to infusion

If yes, please specify reaction: _____

Has the patient ever had challenges with IV starts or been told that they have veins that may be difficult for IV insertions? Yes No

Is the patient pregnant? Yes No (If yes, we are unable to accommodate this patient)

Medical Director Review

Do you wish the patient to be reviewed by our Medical Director at Wellspring Infusion Clinic,
Dr. Tharwat Fera, MD, FRCPC, Clinical Professor UBC? Yes No

Please note: Patients must be covered under BC MSP, otherwise charges will apply for consultation.

Other Infusion Prescriptions

If you would like to prescribe additional infusion medications, please attach the prescription, order, supporting paperwork, and/or lab work.
Or, please contact us by phone.

Dr. Name: _____ Dr. Signature: _____ College ID: _____ Date: _____

Wellspring Infusion Clinic does not provide services to patients under 18 years old or to pregnant women.