Wellspring INFUSION CLINIC

Iron Infusion Referral Form

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 ☐ Monoferric 1500mg IV bolus
(max dose for single infusion is 20mg iron/kg body weight. Dose will be split into two infusions, at least one week apart)

☐ Venofer (iron sucrose) ____mg x ____infusions. Give all doses within ☐ 14 days ☐ 28 days ☐ other: _____

Additional instructions _____

☐ Other: _____

Please remember to supply the patient with lab requisition for 4-6 weeks post infusion

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

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.