# Iron Infusion Referral

Revitalize Wellness RN Inc
4933 51 Ave Vegreville, AB
Fax: 877-908-0158
Email: revitalizewellnessrn@gmail.com

| Patient Information | | | |
|---|---|---|---|
| Patient Name: | | Date of BIrth: | |
| Phone: | | AB Health Care: | |

| Referral Details | | | |
|---|---|---|---|
| Reason for referral: | | | |
| Past Medical History: | | | |
| Patient Weight (KG): | | Date of lab work: (Must be within 30 days at time of referral) | |
| Hgb: | | Ferritin: | |
| Current Medications: | | | |
| Allergies: | | | |
| Is client pregnant or breastfeeding? | | ☐ NO<br>☐ YES | |
| Has Client received IV iron previously? | | ☐ No<br>☐ Yes Any Reaction: | |
| PO Iron Trial :<br>☐ NO<br>☐ YES Formulation: _____ Duration: _____ | | | |

Additional details (Prior/pending workup and/or referrals):

<table>
<tr><th colspan="6">PRESCRIPTION</th></tr>
<tr><td colspan="3">☐ MONOFERRIC</td><td colspan="3">☐ VENOFER</td></tr>
<tr><td colspan="3">Dose Requested: _____<br><table><tr><td>Hemoglobin</td><td>< 50 kg</td><td>50-70 kg</td><td>> 70 kg</td></tr><tr><td>>100</td><td>500 mg</td><td>1000 mg</td><td>1500 mg</td></tr><tr><td><100</td><td>500 mg</td><td>1500 mg</td><td>2000 mg</td></tr></table>*Doses that exceed the weight based chart above, 20 mg iron/kg or 1500 mg must be split into multiple doses separated by at least 7 days.</td><td colspan="3">Dose Requested: _____<br>Maximum treatment regime = 1000mg<br>Max Daily Dose = 300 mg</td></tr>
<tr><td colspan="3">Dose</td><td colspan="3">Dosing Regime</td></tr>
<tr><td>☐ 500 mg</td><td>☐ 1000 mg</td><td>☐ 1500 mg</td><td>☐ 200 mg IV</td><td colspan="2">Every 2 days for 5 doses</td></tr>
<tr><td colspan="3">Total Number of Doses:_____</td><td>☐ 300 mg IV</td><td colspan="2">Every 3 days for 3 doses</td></tr>
<tr><td colspan="6">*Please provide your patient with their required prescription advising them not to fill until notified of their referral status by our clinic. We will direct the patient as to whether or not to fill their prescription dependent on their referral decision.</td></tr>
</table>

| Prescribers Name: | Prescribers Phone/Fax Number: |
|---|---|
| Prescribers Address: | Prescribers Signature |

*Revitalize Wellness is committed to client safety and wellness. All requested services will be reviewed by the clinic's NP lead prior to approval. Infusion services will be provided by Registered Nurses in an RN led clinic.
*Please ensure completeness of your referral and provided history prior to sending. You and your patient will be notified of your referral status upon NP review. Infusion services will be provided in accordance with provincial infusion monographs.
*Please fax the completed referral to our clinic and we will contact the client for booking if accepted. Patients must be provided with required prescriptions presenting with their medications for infusion.

**REMINDER: Services administered by Revitalize Wellness RN Inc will not be covered by Alberta Health. As a result, all infusion services will be subject to a fee and will be the responsibility of the patient. Payment will be required prior to delivery of service. Please ensure your client is aware, we will disclose all costs at the time of booking. More information can be found on our website revitalizewellnessrn.ca**