

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

 Ferinject 500mg infusion Ferinject 1000mg infusion* Ferinject other dosage: _____

(*Max dose for single infusion is 20ml of Ferinject/1000mg per week. If patient requires multiple infusions, these will be spaced at least 1-2 weeks apart. Same cost will apply to subsequent infusions.)

Additional instructions _____

 Monoferic (iron isomaltoside) 500mg Infusion Monoferic 1000mg Infusion Monoferic 1500mg Infusion*

(*Max dose for single infusion is 20mg iron/kg body weight. Dose will be split into two infusions, at least one week apart. Same cost will apply to second infusion.)
 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

 Has Prior Authorization from the patient's private insurance 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.