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ANAM HEALTH

Referral and Delegation Form for Iron Infusion

Please complete electronically and securely fax to the clinic

Referring HCP Information:	**Patient Information:**
Name:_____	Last name:_____
Discipline (MD or NP):_____	First name:_____
CPSO/CNO #:_____	DOB:_____
Phone:_____	Sex:_____
Fax:_____	Phone:_____
Address:_____	Allergies:_____

Indications:

- ☐ Poor response or intolerance to oral iron
- ☐ Iron deficiency anemia
- ☐ Iron deficiency
- ☐ Heavy menstrual bleeding
- ☐ GI conditions affecting absorption
- ☐ CKD
- ☐ Anemia in 2nd/3rd trimester of pregnancy
- ☐ Perioperative optimization
- ☐ Other:_____

Labs Performed in last 1-2 months:

- ☐ Hemoglobin: _____
- ☐ Ferritin: _____
- ☐ TSAT: _____
- ☐ CRP (if applicable): _____

*****Please fax these lab results to the clinic.***

Monoferric (ferric derisomaltose 100mg/ml) dose:

- ☐ 500mg
- ☐ 1000mg
- ☐ Other:_____

DIN 02477777
LU code 610 (ODB for eligible patients)

Frequency:_____

*****The referring HCP is responsible for providing the prescription.***

*****The patient must bring the prescription to their infusion appointment.***

Consent:

The referring HCP has reviewed and documented potential side effects with the patient. The patient has provided informed consent.

- ☐ Yes
- ☐ No

Follow Up:

- ☐ Patient to repeat bloodwork (CBC + iron panel) 4-6 weeks following final infusion
- ☐ Requisition prepared and provided to patient
- ☐ Other testing: _____

Delegation:

I hereby delegate the controlled act of administering intravenous iron to Dr. Gerann Murphy, ND, for the above mentioned patient, in accordance with applicable professional standards and requirements.

Duration of delegation (start date and expiry date): _____

Referring HCP's signature and date: _____