ANAM HEALTH

WHOLE-PERSON CARE

KINGSTON, ONTARIO

Delegation Form for Iron Infusion

Please complete and securely fax to the clinic

REFERRING HCP INFORMATION

Name

Discipline (MD or NP)

CPSO/CNO #

Phone

Fax

Address

PATIENT INFORMATION

Last name

First name

DOB

Sex

Phone

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:

PRESCRIPTION

MONOFERRIC (ferric derisomaltose 100 mg/mL)

Dose: ☐ 500 mg ☐ 1000 mg ☐ Other:

DIN 02477777 LU code 610 (ODB for eligible patients)

Frequency:

Delegating HCP provides the prescription.
Patient brings it to the infusion appointment.

Delegation Form for Iron Infusion

Please complete and securely fax to the clinic

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

☐ Patient to complete pelvic ultrasound to investigate AUB

☐ 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: _____ **Date:** _____