Vitality IV
INFUSION CLINIC
Restoring Iron. Restoring Energy.

Send referrals to:
referrals@vitalityiv.ca
Fax: 844-761-1732

REFERRAL & PRESCRIPTION FORM

NP assessment before every infusion

OceanMD
A WELLSTAR Company

Prefer to refer online?
Submit through OceanMD

PATIENT INFORMATION

Name: _____

DOB: _____ Phone: _____

Address: _____

_____

Health card: _____ Province: _____

Wt (kg): _____

REFERRING PHYSICIAN / NP

Name / title: _____

Licence no.: _____

MSI provider no. (if applicable): _____

Practice: _____

Phone: _____ Fax: _____

Secure report fax / email: _____

CLINICAL INFORMATION

Reason for referral: _____

Allergies / prior iron or B12 reactions (state none known): _____

Recent tests: _____ Attach dated reports.

Pregnant or possibly pregnant? ☐ Yes ☐ No ☐ Unknown ☐ N/A Weeks: _____

IV IRON TREATMENT ORDER

IV iron: adults 18+. Select one medication and dose.

Monoferric (ferric derisomaltose)

IV infusion | Max 20 mg/kg; >1,500 mg not recommended

☐ **500 mg** - Minimum weight 25 kg
☐ **1,000 mg** - Minimum weight 50 kg
☐ **1,500 mg** - Minimum weight 75 kg

Other dose (mg): _____

Ferinject (ferric carboxymaltose)

Max 15 mg/kg; max 1,000 mg per infusion and week

☐ **500 mg** - Minimum weight 34 kg
☐ **1,000 mg** - Minimum weight 67 kg

No single dose above 1,000 mg.

Other dose (mg): _____

Weight alone does not determine dose. Dose requires patient-specific assessment.

VITAMIN B12 TREATMENT ORDER

☐ Cyanocobalamin (vitamin B12) Other B12: _____

Dose (units): _____ Route: _____ Frequency: _____

PRE-MEDICATION CONSIDERATIONS - Select all that apply

☐ Methylprednisolone (Solu-medrol)125mg IV ☐ Cetirizine 10mg PO

Indication: ☐ Hx of ≥2 drug allergies ☐ Asthma ☐ Prior mild hypersensitivity to IV iron
☐ Inflammatory Arthritis ☐ Other: _____

Prescriber signature: _____ Date (YYYY-MM-DD): _____

NS Pharmacare exception status: ☐ Requested ☐ Approved ☐ Not applicable

IV IRON DISPENSING Select one.

☐ **Patient's chosen pharmacy**
Name/location _____ Fax _____

☐ **Maze Rx Pharmacy**
Fax 833-666-0564

Prescription sent to the chosen pharmacy? ☐ Yes ☐ Pending
Prescriber to fax a copy of this signed referral and prescription form directly to the patient's chosen pharmacy.