INITIUM | CENTRE FOR PAIN MEDICINE

FAX: 778-757-1306

IV Iron Infusion Referral Form

PATIENT INFORMATION

Name: _____ **PHN:** _____

Date of Birth (MM/DD/YYYY): _____ **Phone Number:** _____

Address: _____ **Email:** _____

Consent to receive Email: ☐ **Yes** ☐ **No**

REASON FOR REFERRAL: Iron deficiency *+/-* anemia **AND** oral replacement therapy ineffective or not tolerated

REFERRING PROVIDER INFORMATION

Referring Provider: _____ **MSP #:** _____

Clinic: _____

Provider Fax/Email: _____ **Provider Phone: 778 757 1302** _____

LABORATORY

Please attach most recent relevant bloodwork, or complete the fields below:

Hgb: _____ **Date:** _____

Ferritin: _____ **Date:** _____

Transferrin Saturation: _____ **Date:** _____

MEDICAL HISTORY

Has the patient had an ALLERGIC/ADVERSE reaction to a previous iron infusion? ☐ Yes ☐ No

If yes, please specify: _____

Does the patient have any other known conditions that can be contributing to iron deficiency? ☐ Yes ☐ No

If yes, please specify: _____

Does the patient have asthma / inflammatory arthritis? ☐ Yes ☐ No

Other Allergies: _____

Is the patient pregnant? ☐ Yes ☐ No **Due Date:** _____

ORDERS

☐ Monoferric 500mg ☐ Monoferric 1000mg ☐ Monoferric 1500mg ☐ Clinic physician recommendation

☐ Other: _____