



# MD INJECTION CLINIC

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15350 Croydon Dr #201B, Surrey, BC V3Z 0Z

## Iron Infusion Referral Form

### Patient Information

Patient Name: \_\_\_\_\_ Date of Birth (dd/mm/yyyy): \_\_\_\_\_

Phone Number: \_\_\_\_\_ PHN: \_\_\_\_\_

Current Address: \_\_\_\_\_

### Indication

Iron deficiency +/- anemia requiring parenteral iron

### Prescription

Monoferric (iron isomaltoside) 500mg IV bolus       Monoferric 1000 mg IV bolus

Delivery:  Pick up at pharmacy       Delivery to MD Injection Clinic

### Lab Work

Please attach most recent relevant lab work or provide the following:

Hb: \_\_\_\_\_ Date: \_\_\_\_\_

Ferritin: \_\_\_\_\_ Date: \_\_\_\_\_

Transferrin Saturation: \_\_\_\_\_ Date: \_\_\_\_\_

### Relevant Patient Information

Patient weight (required to calculate appropriate dosage): \_\_\_\_\_

Has the patient experienced an allergic or adverse reaction to iron infusion in the past? Yes No

If yes, please specify: \_\_\_\_\_

Does the patient have asthma, eczema, other atopic allergy, or an immune or inflammatory condition?

Yes No

If yes, please specify: \_\_\_\_\_

Is the patient allergic to any medication? Yes No

If yes, please specify: \_\_\_\_\_

Is the patient pregnant? Yes No

Dr. Name: \_\_\_\_\_ Dr. Signature: \_\_\_\_\_ Date: \_\_\_\_\_