IV IRON REFERRAL FORM

1927 Ironoak Way, Oakville, ON, L6H 0N1
P: (905) 636-9387 | F: (905) 636-9388

PATIENT INFORMATION

Full Name: _____ Date of Birth: _____

Phone #: _____ Email Address: _____

Address: _____ City: _____ Province: _____

Postal Code: _____ HCN with VC: _____

Hb (g/L): _____ Ferritin (ng/L): _____ Date of Last Blood Test: _____

Weight (kg): _____ Allergies: _____

Pregnant: ☐ Y ☐ N Recent Blood Test Attached: ☐ Y ☐ N

Emergency Contact: _____ Emergency Contact Phone #: _____

IRON MEDICATION

☐ **Monoferric (ferric derisomaltose):** _____ (mg) - *Maximum dose per IV session 1000 mg*

☐ **Venofer (iron sucrose):** _____ (mg) - *Maximum dose per IV session 300 mg*

REFERRING PHYSICIAN INFORMATION

Physician's Name: _____ License #: _____ OHIP #: _____

Clinic Name: _____ Address: _____

City: _____ Province: _____ Postal Code: _____

Clinic Phone #: _____ Clinic Fax #: _____ Clinic Email: _____

Physician's Signature: _____ Date: _____

Please fax completed forms to (905) 636-9388