



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 session 1000 mg*
 Venofer (iron sucrose): _____ (mg) - *Maximum dose per session 1000 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