



## IRON INFUSION REFERRAL FORM

### Patient Information

Patient Name:		DOB:	
PHN:		Phone:	
Email (optional):			

Allergies:	<input type="checkbox"/>	NKDA	<input type="checkbox"/>	Known drug allergies to: _____
Pregnancy Status:	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes, _____ trimester (1st trimester contraindicated)
Notes:				

### Indications for IV Therapy

- |  |   |
|--|---|
| <input type="checkbox"/> Iron deficiency anemia            | <input type="checkbox"/> Intolerance/inadequate response to oral iron |
| <input type="checkbox"/> Low ferritin with symptoms        | <input type="checkbox"/> Malabsorption                                |
| <input type="checkbox"/> Pregnancy-related iron deficiency | <input type="checkbox"/> Chronic blood loss                           |
- Other: \_\_\_\_\_

**Recent Laboratory Values** (Please include recent iron studies if available – inclusion of labs with this form is preferred). Labs must be within past 3 months.

Hemoglobin (g/L):		Ferritin µg/L:		Date:	
TSAT % (if available):		CRP (if available):			

### Additional Clinical Information / Notes:

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### Referring Provider Information:

Referring Provider:		Designation:	
Phone:		Date:	
Clinic:		Fax:	

**Signature:** \_\_\_\_\_

Thank you for your referral.  
 We will contact your patient directly to arrange consultation and infusion.  
 Please fax completed referral to: **250-391-0056**

Form downloads can be found at:  
<https://www.drspencernd.com/iron-referral>