Aurora Health & Wellness — Iron Infusion Program
Dr. Stephanie Spencer, ND 778 Goldstream Ave, Victoria, BC V9B 2X3
Phone: (250) 391-0056 Fax: (250) 410-7031

IRON INFUSION REFERRAL FORM

Patient Information

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

Allergies: ☐ NKDA ☐ Known drug allergies to: _____

Pregnancy Status: ☐ No ☐ Yes, _____ trimester (1st trimester contraindicated)

Notes:

Indications for IV Therapy

☐ Iron deficiency anemia
☐ Low ferritin with symptoms
☐ Pregnancy-related iron deficiency
☐ Intolerance/inadequate response to oral iron
☐ Malabsorption
☐ 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:

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: **250-410-7031**