Iron Referral Form

14022 32 Ave Unit #401, Surrey, BC V4P 2J2
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Dr. Mohamed, ND

Patient Name First and Last Name		PHN Health Number	
Date of Birth (MM / DD / YYYY)		Phone Number contacted to arrange the appointment time	

SECTION A: IRON INFUSION

Indication: Iron deficiency +/- anemia AND oral replacement therapy ineffective.

LABORATORY

Please include the most recent bloodwork or ask patient to send a copy to our clinic and fill the relevant information below:

HGB		Date	
Ferritin		Date	

MEDICAL HISTORY

Patient Age		Patient Weight	

Has the patient had an ALLERGIC/ADVERSE reaction to a previous iron infusion? ☐ Yes ☐ No

If yes, please specify

Does the patient have any autoimmune conditions/inflammatory arthritis? ☐ Yes ☐ No

Allergies

Is the patient pregnant? ☐ Yes ☐ No Due Date

ORDER (if requesting a specific iron)

Indication: Iron deficiency +/- anemia AND oral replacement therapy ineffective.

☐ Monoferric 500mg ☐ Monoferric 1000mg
☐ Iron Sucrose _____ x 200mg infusions ☐ Iron Sucrose _____ x 300mg Infusions

ADDITONAL INFORMATION FOR DR.MOHAMED, ND

Referral Provider Name:

Referral Provider Signature:

Clinic Name/Phone Number:

Date: