Mainline

DATE OF IV _____ (internal use only)

Infusion Referral

for Infusion at **Integrated Health Clinic** (IHC)

FAX TO 604-888-8365
admin@integratedhealthclinic.com
Questions call 604-888-8325

Location

◯ 2nd Floor 23242 Mavis Ave
Fort Langley BC

Patient Name: _____ PHN: _____

Date of Birth: _____ Phone Number: _____

(MM / DD / YYYY)

Patients will be called by IHC Staff to arrange the appointment time

Section A Iron Infusion

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

Laboratory

Please fax most recent relevant bloodwork or fill in the relevant information below:

Hgb: _____ Date: _____

Ferritin: _____ Date: _____

Transferrin Saturation: _____ Date: _____

Allergies

Has the patient ever had an infusion reaction to iron in the past? ◯ Yes ◯ No

If yes, please specify: _____

_____

Does the patient have asthma/inflammatory arthritis? ◯ Yes ◯ No

Other Allergies: _____

_____

Orders

◯ Monoferric 1000mg ◯ Iron Sucrose

◯ Monoferric 500mg _____ x 250mg Infusion(s)

Is the patient pregnant?

◯ Yes ◯ No

Section B Relevant medical info:

Physician Name: _____ Clinic Name/Phone Number or Stamp:

Physician Signature: _____ Date: _____ _____

* IHC charges a $235 infusion fee per infusion. Please have patients check with their insurance providers for coverage.

PLEASE FAX THIS FORM TO IHC: 604-888-8365