

Iron Infusion Referral Form

Section A: Patient Information

Patient Name: _____ PHN (if applicable): _____

Date of Birth: _____ Phone Number: _____

Email: _____

Indication

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

Laboratory Values

Please include most relevant bloodwork or fill in the relevant information below (within the last 3 months):

Hemoglobin (Hgb): _____ Date: _____

Ferritin: _____ Date: _____

Transferrin Saturation: _____ Date: _____

Medical History

Has the patient had an allergic/adverse reaction to previous iron infusion? Yes / No

If yes, please specify:

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

Other allergies: _____

Is the patient pregnant? Yes / No If yes, Due Date: _____

Section B: Infusion Orders

Monoferric 500 mg Monoferric 1000 mg Monoferric 1500 mg

Other (specify): _____

Please attach most recent relevant bloodwork and supporting documentation.

Patients will be contacted to arrange appointment time.

Payment and insurance verification is the responsibility of the patient.

Physician Name:		Clinic Name:	
Phone Number:			
Email:			
Signature:		Date (MM/DD/YYYY):	