

Hematology and Iron Infusion Clinic



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This form can also be submitted on line: www.heme-iron-infusion.ca

IRON INFUSION REFERRAL

Patient Name: _____ PHN: _____

Date of Birth: _____ Phone Number: _____

Email: _____ Address: _____

DIAGNOSTIC SERVICES

☐ Iron deficiency anemia AND oral replacement therapy ineffective OR not tolerated

☐ Heart- Failure – Iron deficiency (with or without anemia)

Laboratory

Fill in the most recent relevant information below:

Hgb: _____ Date: _____

Ferritin: _____ Date: _____

Transferrin Saturation (if available): _____ Date: _____

Relevant Patient Information

Has the patient experienced an **allergic/adverse** reaction to a previous iron infusion? ☐ Yes ☐ No

If yes, please specify: _____

Does the patient have asthma, severe eczema, inflammatory arthritis? ☐ Yes ☐ No

If yes, please specify: _____

Other allergies or important information: _____

Is the patient pregnant? ☐ Yes ☐ No

Physician Name or stamp: _____ Clinic Tel Number: _____

Date: _____ Fax: _____