# INFUSION REFERRAL

672 Leg in Boot Square
Vancouver, BC V5Z 4B5
mainlinewellness.ca

FAX to 604-398-2628
Tel: (604) 876-2344
info@mainlinewellness.ca

Patient Name: ______________________ PHN: ______________________

Date of Birth: ______________________ Phone Number: ______________________
(MM / DD / YYYY)
Patients will be called by Mainline Staff to arrange the appointment time

## SECTION A IRON INFUSION

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

### LABORATORY

Please fax most recent relevant bloodwork or fill in the following:

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 ☐ Other: ______________

☐ Monoferric 500mg ______ x 250mg Infusion(s)

### IS THE PATIENT PREGNANT?

☐ Yes ☐ No

## SECTION B OTHER INFUSION ORDERS eg: Bisphosphonates, Remicade, Magnesium

Please attach specific requests for other infusions along with supporting paperwork or lab values. Patients will be required to bring the medications with them. Our supervising physician may require a telephone conversation with the referring physician prior to commencing.

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

Physician Signature: ______________ Date: ______________ ______________________

*Mainline charges an infusion fee for each treatment. Please have patients check with their insurers if they are planning on claiming the service. Full payment for all iron infusions will be required at the 1st appointment.