



INFUSION REFERRAL

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

FAX to 604-608-3447
or email info@mainlinewellness.ca
Tel: (604) 876-2344

Patient Name: _____

PHN: _____

Date of Birth: _____
(MM / DD / YYYY)

Phone Number: _____
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.