Internal Medicine Service Referral Form Dr. Kevin McLeod MD, FRCPC, ABIM

Suite 200 – 101 West 16th Street, North Vancouver
Phone: 604-904-0810 Fax: 604-904-0812

www.mcleodmedical.com www.liberationfitness.ca

FAX FORM TO 604-904-0812 – PATIENT WILL BE CONTACTED

PATIENT INFORMATION

Last Name: First Name:

Telephone/Contact:

PHN:

DOB: Referring physician:

DIAGNOSTIC SERVICES

☐ Iron deficiency +/- anemia

☐ HF-ID

Hgb:_____Date:_____

Ferritin:_____Date:_____

Transferrin Saturation:_____
Date:_____

IRON INFUSION Referral

☐ FERINJECT 500mg

☐ FERINJECT 1000mg

☐ FERINJECT other_____mg

NOTE: Maximum cumulative dose for treatment : 15mg/kg -Maximum dose per week: 1000mg Treatment dose will be split accordingly to bodyweight.

ADDITIONAL INFORMATION

PHYSICIAN'S SIGNATURE **DATE**