Family Health Hub
Walk-In Clinic and Family Practice
190-2525 Old Bronte Road,
Oakville, ON L6M 4J2

Phone: 905-420-7840
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https://familyhealthhub.com
contact@familyhealthhub.com

FERINJECT IV IRON REFERRAL FORM

PATIENT INFORMATION (Fill out patient information or affix patient label)

Full name: _____Date of birth (DD/MM/YYYY): _____
Address: _____City: _____ Province: _____ Postal code: _____
Preferred phone: _____ Alternate phone: _____ Email: _____
Health Card #: _____ Allergies: _____
Emergency Contact Name: _____Emergency Contact Phone: _____

PRESCRIPTION INFORMATION

Diagnosis: _____ Hemoglobin: _____g/L Ferritin: _____ng/mL
TSAT (if applicable): _____; Patient weight: _____lbs _____kg Date of weight: _____

Pregnant? ☐ Yes ☐ No

New to Iron Infusions? ☐ Yes ☐ No If no, indicate reaction details, if applicable: _____

MEDICATION

☐ **Ferinject** Maximum dose for treatment: 15mg/kg | 1000mg per infusion. Treatment dose will be split according to bodyweight.

Pregnancy: Maximum cumulative dose (gestation week ≥16) is restricted to 1000mg for patients with Hb >90g/L or 1500mg in patients with Hb≤90g/L.

Hb (g/L)	Bodyweight <35 kg	Bodyweight 35 kg to <70 kg	Bodyweight ≥70 kg
< 100	☐ 500 mg	☐ 1500 mg	☐ 2000 mg
100 to <140	☐ 500 mg	☐ 1000 mg	☐ 1500 mg
≥140	☐ 500 mg	☐ 500 mg	☐ 500 mg

PRESCRIBER INFORMATION

Prescriber name: _____ License # _____
Address: _____ City: _____ Province: _____ Postal code: _____
Contact name: _____ Phone: _____
Fax: _____ Email: _____
Prescriber Signature: _____ Date: _____
Please remind patient to bring their health card at their visit. Please note, a sitting fee applies to each infusion.

UPON COMPLETION FAX TO: **905-215-0711**