

Dr. Andrew H. Yu – Rapid Access IV Iron Clinic
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IRON INFUSION REFERRAL
FAX to : 604-439-0004

Patient Name: _____ PHN: _____

Date of Birth: _____ Phone Number: _____

DIAGNOSTIC SERVICES

Iron deficiency anemia AND oral replacement therapy ineffective

Heart Failure - ID

Laboratory

Fill in the most recent relevant information below:

Hgb: _____ Date: _____

Ferritin: _____ Date: _____

Transferrin Saturation: _____ Date: _____

Relevant Patient Information

Patient weight: _____ kg

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

Orders

Ferinject 500mg Ferinject 1000mg Ferinject other: _____ mg

Physician Name: _____ Clinic Name/Phone Number: _____

Physician Signature: _____ Date: _____ email/Fax: _____