

RevIVe Iron Clinic

1100 University Avenue West, Windsor, ON N9A 5S7
Ph: 519-997-2404 | Fax: 519-255-3239

Iron Infusion Referral / Order Form

Patient Name:

HCN:

DOB:

Phone:

Address:

Family Physician:

Indication:

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

Laboratory investigations: Please fax relevant blood work done within the last 3 months.

Allergies:

Has the patient ever had an infusion reaction in the past? Yes No

If yes, please specify:

Does the patient have asthma/inflammatory arthritis? Yes No

Impaired renal and liver function? Yes No

Select IRON TYPE (choose ONE):

Ferric Carboxymaltose

Ferric Derisomaltose

Select DOSE (choose ONE):

500 mg IV once, mix in 100 mL NaCl 0.9% (#1 dose)

750 mg IV once, mix in 100 mL NaCl 0.9% (#1 dose)

1000 mg IV once, mix in 250 mL NaCl 0.9% (#1 dose)

Note: Ensure the selected dose is appropriate for the chosen iron product.

Referring Physician

Physician Name:

Signature:

Clinic Name/Phone/Fax or Stamp:

Date:

Fax completed referral and prescription to: 519-255-3239

**Referral will be declined if blood work is not recent.*

***This service is not covered by OHIP; infusion fee applies and iron therapy may or may not be covered.*

A physician is on site at all times. RevIVe will contact the patient directly to arrange the initial consultation.

Disclaimer: The referring healthcare provider retains full responsibility for ongoing assessment, monitoring, and follow-up care of the patient following infusion therapy.