Dunbar Family Practice

IV IRON
Referral form
*for non-pregnant adults

T:(519)621-4071
F:1-888-398-1833

PATIENT INFORMATION (or affix label)

Full name: ___________________________ Date of birth (DD/MM/YYYY):____________________
Address: _______________________________ City: __________________________ Province: ________
Postal code: _______________ Preferred phone: _____________ Alternate phone: ________________
Email: ____ HCN with VC: _______________________________
Allergies: ____

PRESCRIPTION INFORMATION

Hb:________ g/L Ferritin:_______ ng/L Date of blood test (within 8 wks):____________________
Patient weight:_____lb _____kg Pregnant? Yes☐ No☐
First iron infusion? Yes ☐ No ☐
If no, include reaction details, if applicable___________________________________

MEDICATION

☐ **Monoferric (ferric derisomaltose)** Maximum dose for treatment: 20mg/kg. Maximum dose per day: 1000mg. Treatment dose will be split according to bodyweight and Hb result.

☐ **Ferinject (ferric carboxymaltose)** Maximum dose for treatment: 15mg/kg. Maximum dose per day: 1000mg. Treatment dose will be split according to bodyweight and Hb result.

DISPENSING AND PICK UP

☐ The patient prefers to pick up product from St. Michael Medical Pharmacy (located inside Dunbar Family Practice). We will send prescription.

☐ The patient prefers to use a different pharmacy, **the referring provider must issue and send the prescription**

The patient is responsible for providing insurance details and/or payment to the pharmacy at pick up. **The patient must pick up the iron product before the appointment.**

COVERAGE AND FEES

This clinic charges an infusion fee of **$150/session**. This is not covered by OHIP, and in most cases, is not covered by private insurance. We will issue an invoice for each session.

☐ **Referring provider must confirm that the patient has been notified of the above fees**

REFFERING PHYSICIAN INFORMATION

Prescriber name: ______________________License # : ______________OHIP # : __________________
Address: _______________________________ City: __________________________ Province: ________
Postal code: ___________________________ Phone: ____
Fax: ____ Email: ______________________________________
Signature: _____________________________

UPON COMPLETION FAX TO: 1-888-398-1833