



# INVICTUS HEALTH GROUP

NAVIGATING HEALTH, TOGETHER.

## INVICTUS HEALTH GROUP

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308 - 8425 120 Street  
Delta, BC V4C 6R2

### IV IRON INFUSION REFERRAL FORM

PATIENT INFORMATION	
Full Name: _____	
Date of Birth (DD/MM/YYYY): _____	Phone: _____
PHN: _____	Email: _____
Address: _____	
INDICATION FOR IV IRON THERAPY	
Iron deficiency +/- anaemia where oral iron is not tolerated or effective	
LABORATORY RESULTS	ORDER
Please provide the following values:	<input type="checkbox"/> Monoferric 500mg
Hgb: _____	<input type="checkbox"/> Monoferric 1000mg
Ferritin: _____	<input type="checkbox"/> Monoferric 1500mg
Transferrin Saturation: _____	<input type="checkbox"/> Iron Sucrose (Venofer): _____ mg x _____ infusions
	<input type="checkbox"/> Other: _____
MEDICAL INFORMATION	
Has the patient had an allergic reaction to an IV Iron Infusion in the past <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please specify: _____	
Does the patient have asthma, inflammatory arthritis, severe eczema, or multiple drug allergies <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please specify: _____	
Is the patient Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, regrettably we do not provide IV iron infusions for pregnant patients at this time)	
<b>*Please attach patient's medical history, current medications, and most recent bloodwork*</b>	
REFERRING PHYSICIAN INFORMATION	SIGNATURE OF REFERRING PHYSICIAN
Ordering Physician: _____	Signature: _____
MSP #: _____	Date: _____