FERRA
HEMATOLOGIST-LED IV IRON INFUSION CLINIC

411-1200 Burrard St, Vancouver, BC V6Z 2C7
Fax: (604) 398-6450 | referrals@ferraclinic.ca

IV Iron Infusion Referral

PATIENT INFORMATION

Patient Name: ____________________ PHN: ____________________

Date of Birth: ____________________ Phone: ____________________

Email: ____________________

Pregnant? ☐ Y ☐ N   Serious infusion reaction to IV iron in past? ☐ Y ☐ N

INDICATION

☐ Iron deficiency (ID) or Iron deficiency anemia (IDA) — oral iron ineffective or not tolerated

☐ Iron deficiency in heart failure (HFrEF)

☐ Other: ____________________

DRUG COVERAGE

☐ Extended health plan

☐ None

RECENT LAB VALUES

Labs must be within 2 months.

Date of Labs: ____________________

Hgb: ____________________ Ferritin: ____________________ TSAT: ____________________

PRESCRIPTION

Ferinject (ferric carboxymaltose) or Monoferric (ferric derisomaltose)
Dose calculated by clinic based on weight and Hgb.

**Final iron formulation and dose to be determined by Hematology.*

REFERRING PHYSICIAN

Physician Name: ____________________ MSP #: ____________________

Clinic / Phone: ____________________ Fax / Email: ____________________

Date: ____________________

Patients can expect a call from the clinic within 1-3 business days of the referral being received.

Fax completed referral with recent labs to (604) 398-6450

Please attach relevant patient medical history, allergies, and current medication list.

Questions? referrals@ferraclinic.ca