



AESTHETIX MD

QUALITAS CARE CLINIC
COSMETIC · MEDICAL · WELLNESS

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REFERRAL & TREATMENT ORDER

IV Iron Infusion

Please attach labs drawn within the last 3 months

FAX COMPLETED FORM TO

587-689-3184

01 PATIENT INFORMATION

Full name _____ Date of birth (YYYY / MM / DD) _____ / _____ / _____

Phone _____ Alberta Health Care # _____

Address _____

Weight (kg) _____ Height (cm) _____ Allergies _____

02 INDICATION

Diagnosis

- ☐ Iron deficiency anemia
☐ Iron deficiency without anemia

Reason IV iron is required

- ☐ Intolerance to oral iron
☐ Poor response to oral iron (≥ 8 weeks)
☐ Malabsorption – celiac, IBD, bariatric surgery
☐ Ongoing blood loss – menstrual, GI
☐ Pregnancy (2nd/3rd trimester) or pre-op
☐ Other _____

03 RECENT LABORATORY RESULTS

HEMOGLOBIN	FERRITIN	TSAT	MCV	eGFR	DATE DRAWN
g/L	$\mu\text{g/L}$	%	fL	mL/min	yyyy/mm/dd

- ☐ Lab report attached ☐ Cause of iron deficiency investigated

04 SAFETY SCREENING

Previous IV iron	☐ Y ☐ N	Reaction to previous IV iron	☐ Y ☐ N
Drug allergies, asthma or severe eczema	☐ Y ☐ N	Currently pregnant	☐ Y ☐ N
Active infection or fever	☐ Y ☐ N	Iron overload or hemochromatosis	☐ Y ☐ N

If yes, details _____

05 INFUSION ORDER

Product

- ☐ Ferric derisomaltose (Monoferic)
☐ Iron sucrose (Venofer)
☐ Per clinic protocol – dosed on weight and Hb
☐ Other _____

Coverage

- ☐ Private insurance ☐ Alberta Blue Cross
☐ Special authorization ☐ Self-pay

Dose

Total iron dose (mg) _____
Dose per infusion (mg) _____
No. of infusions _____

Follow-up labs

CBC, ferritin, TSAT 4-8 wks after last infusion.

06 REFERRING PHYSICIAN / CLINIC

Name _____

Clinic / practice _____

Signature _____

Billing / Prac ID # _____

Phone _____

Fax _____

Date (YYYY / MM / DD) _____ / _____ / _____

THANK YOU FOR YOUR REFERRAL