Referral/Delegation Form – IV Iron Infusions

Practitioner Information

Referring Practitioner's Name: ______________________________

Type of Provider (MD/ND/NP): ______________________________

Clinic: ______________________________

Phone: ______________________________

Email: ______________________________

Patient Information

Patient Name: ______________________________

Date of Birth (DD/MM/YYYY): ______________________________

Phone: ______________________________

Email: ______________________________

Health Card Number: ______________________________

Patient Treatment Information

Urgency of Infusion: ☐ Routine ☐ Urgent

CC/Diagnosis: ______________________________

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Current Medications & Natural Health Products (include dose, frequency, indication):

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Relevant Clinical Notes: ____

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Medical History

Allergies (medications or otherwise): ☐ No ☐ Yes

If yes, please specify: ____

Kidney or Liver Dysfunction: ☐ No ☐ Yes

If yes, please specify: ____

Adverse Reaction to IV Therapy: ☐ No ☐

If yes, please specify: ____

Other Relevant Information: ____

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Delegation of Treatment

Are you delegating this IV Iron Infusion to our team: ☐ No ☐ Yes

☐ Consent provided for Delegation of this controlled act

Delegation Expiry:
☐ 6 months ☐ 12 months from approval date

If yes, please ensure you fax the prescription to a pharmacy for the patient to bring to the appointment as we do not have IV Iron in stock.

If not, we will book the patient with our NP to prescribe and delegate the IV Iron Infusion. Please review the Required Laboratory Tests section.

Required Laboratory Tests
The following labs are required for IV Iron Infusions:

- CBC
- Ferritin
- Creatinine / eGFR
- ALT

☐ **Lab results attached** (within last 3 months)
☐ **Not available** – Please note: Our NP will order these as part of the consultation fee.

Prescription Details:

☐ 500mg IV Monoferric in single infusion
☐ 1000mg IV Monoferric in single infusion
☐ 1500mg IV Monoferric in single infusion
☐ Other: ______________________________

☐ Iron Prescription has been provided to patient

Note: Total iron need (mg) = Body weight (kg) x [Target hemoglobin - actual hemoglobin (g/dL) x 2.4] + iron stores (500 mg)

Would you like a summary note after the treatment?
☐ **Yes**
☐ **No**

Referring/Delegating Practitioner Signature: ______________________________

Registration #: ______________________ Date: ____________________

This Referral/Delegation Form is valid for 12 months from the date it is signed.

Please fax/email this completed referral and lab results (if available) to:

Email: ivtherapy@thesageclinic.com
Fax: (519) 954-6702