

Iron Infusion Referral Form

Patient

Name: _____	DOB: _____
Address: _____	
City, state, zip: _____	
Cell: _____	Home: _____
Diagnosis(es): _____	
Medications/supplements: _____	

Allergies: _____	

Referring Physician

Provider name: _____		
Clinic name: _____		
Address: _____		
City, state, zip: _____		
Phone: _____	Fax: _____	Email: _____

IV Protocol

Venofer (iron sucrose) dosage: <input type="checkbox"/> 100mg <input type="checkbox"/> 200mg
Duration: once per week for _____ weeks
*First dose is always 100mg to assess safety and tolerability.
*Labs required: CBC, iron, ferritin, TIBC, and liver enzymes

Physician signature: _____ Date: _____

Please fax this form along with labs and chart notes to (425) 391-8091