DermaSculpt
MEDICAL AESTHETICS
437-247-6304
20 Leslie St, Unit 206, Suite 18, M4M 3L4
@dermasculptme
www.dermasculpt.ca | info@dermasculpt.ca

Date: _____

IV Iron Infusion Referral Form

Patient Information

Full Name: _____ Date of Birth: ____ / ____ / _____
Address: _____
Phone #: _____ Email: _____
Preferred Contact Method: ☐ Phone ☐ Email ☐ Text

Reason for Referral:

☐ Iron repletion for Iron Deficiency Anemia (IDA)
☐ Correction of Non Anemia Iron Deficiency (NAID)
☐ Ferritin >30 µg/L with symptoms of iron deficiency (e.g. fatigue, hair loss, RLS, mood)
☐ Other: _____
Date: _____ ☐ Hgb _____ ☐ Ferritin _____ Iron _____ TIBC _____ T-Sat ___

IV Iron Prescription & Required Bloodwork:

☐ Monoferric (ferric derisomaltose) 1000mg IV single dose faxed to pharmacy
**use LU code 610 (if IDA + failed oral iron + no iron overload)
Attach bloodwork within last 3 months: CBC, Fe, Iron Panel (serum Iron, TIBC, T-Sat)

Patient History:

☐ Oral iron trial attempted and ineffective or not tolerated
☐ Patient has no known drug allergies or history of severe asthma
☐ Patient has had IV iron in the past with no known major adverse reactions to infusion
☐ Patient is not pregnant
☐ Patient is 18 years old and >50kg (for patients <50 kg, a dose of 20mg/kg is used)
☐ Patient has no active infection or inflammatory illness at time of referral

Medical History / Medications/ Relevant Info:

_____

_____

Additional Injectable Therapies (if indicated): ☐Vitamin B12 IM ☐Vitamin D 50,000IU IM

Referring Provider Information

Provider: _____ Address: _____
Phone #: _____ Fax #: _____
Provider Signature: _____

Infusions are administered in a monitored clinical setting with emergency medications available onsite.

Please fax completed referral form to 1-877-762-1217