Patient Name:

Date of Birth: Phone Number:

(MM / DD / YYYY) Patients will be called by Mind Body Soul Staff to arrange your appointment time

**IRON INFUSION**

SECTION A

Indication: Iron deficiency +/- anemia **AND** oral iron replacement therapy ineffective.

# LABORATORY

Please fax most recent relevant bloodwork and fill in the following:

Hgb: Ferritin:

Transferrin Saturation:

Date: Date: Date:

# ALLERGIES

Has the patient ever had an infusion reaction to iron in the past? Yes No

*If yes, please explain:*

Does the patient have asthma/inflammatory arthritis? Yes No

*Other Allergies:*

# ORDERS

Monoferric 1000mg Monoferric 500mg

Iron Sucrose

x 250mg Infusion(s)

Other:

IS THE PATIENT PREGNANT?

Yes No

Clinic Name/ Phone Number or Stamp

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature: Date:

Mind Body Soul Integrative Clinic charges an infusion fee for each treatment, due at the time of your appointment. Please check with your

insurance provider if you are covered for this service and wish to claim it.

302-1630 Pandosy Street Kelowna, BC V1Y1P7 - [info@mindbodysoulkelowna.com](mailto:info@mindbodysoulkelowna.com) - Phone: 250 868 0221 - Fax: 250 869

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