Infusion Referral Vancouver Clinic

FAX TO 604-608-3447
or email info@mainlinewellness.ca

672 Leg in Boot Square
Vancouver, BC V5Z 4B5

(604) 876-2344
mainlinewellness.ca

Patient Name: _____ PHN: _____

Date of Birth: _____ Phone Number: _____
(MM / DD / YYYY)

Patients will be called by Mainline Staff to arrange the appointment time

Section A Iron Infusion

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

Laboratory

Please fax most recent relevant bloodwork or fill in the relevant information below:

Hgb: _____ Date: _____

Ferritin: _____ Date: _____

Transferrin Saturation: _____ Date: _____

Allergies

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

If yes, please specify: _____

_____

Does the patient have asthma/inflammatory arthritis? ◯ Yes ◯ No

Other Allergies: _____

_____

Orders

◯ Monoferric 1000mg ◯ Iron Sucrose ◯ Other: _____

◯ Monoferric 500mg _____ x 250mg Infusion(s)

Is the patient pregnant?

◯ Yes ◯ No

Section B Other infusion orders

eg: Bisphosphonates, Remicade, Magnesium

Please attach specific requests for other infusions along with supporting paperwork or lab values.

Patients will be required to bring the medications with them. Our supervising physician may require a telephone conversation with the referring physician prior to commencing.

Physician Name: _____ Clinic Name/Phone Number or Stamp: _____

Physician Signature: _____ Date: _____ Email/Fax: _____

* Mainline charges an infusion fee for each treatment. Please have patients check with their insurers if they are planning on claiming the service. Full payment for all iron infusions will be required at the 1st appointment.