Flow IV Mobile and In-Clinic Infusion Services
www.flowiv.ca | info@flowiv.ca | Ph:403-836-1513 | Fax: 403-236-5923

Infusion Referral Form

Patient Information
Name:_____
DOB:_____
Address:_____
Phone:_____

Physician Information
Office:_____
Doctor:_____
Phone:_____
Email:_____

Infusion Type

- ☐ Monofer (iron isomaltoside) 500mg Bolus
- ☐ Monofer (iron isomaltoside) 1000mg Bolus
- ☐ Venofer ____mg ____ x time(s) weekly x_____ Infusion(s)
- ☐ Additional Instructions _____
- ☐ Other: _____

Patient History

- ☐ Iron Labwork Within the last 3 months (Please attach) OR:
- ☐ HBG:_____
- ☐ Ferritin:_____
- ☐ Transferrin Saturation _____
- ☐ Has the patient had an Iron infusion in the past? If yes, please explain:

_____

Allergies_____

Relevant Medical History_____

_____

_____

By signing this document, I am aware that I, the referring Prescriber, am responsible for all follow-up appointments necessary, including blood work requisitions and further direction for the patient.

Physician Prescription: Please attach/Send to patient pharmacy

Signature_____ Date_____