www.Drip-Wellness.com DRIP WELLNESS CLINIC (Ph) 425-386-9505
(Fax) 425-386-9522

IV Therapy: Iron Infusion
Referral Form

Patient Information:

Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

Cell: _____Home: _____

Email: _____

Diagnosis(es)_____

Referring Physician:

Provider Name: _____

Clinic Name: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Email: _____

IV Protocol:

Venofer (Iron sucrose) dosage: ☐ 100mg ☐ 200mg

Duration: once a week for_____week(s). Other_____

-Add mini IV bag of Vitamin C (ascorbic acid) 2000mg to follow Iron Infusion: **Y/N**

***Labs recommended: CBC, Iron, Ferritin, TIBC, Liver Enzymes*

Physician Signature: _____ Date: _____

PLEASE **FAX** THIS FORM ALONG WTH ANY LAB WORK TO THIS NUMBER:

425-386-9522

info@Drip-Wellness.com