Aeon Future Health
Infusion Referral Form

Email to admin@aeonfuturehealth.com
Or fax to 403-517-7666
Tel: 403-454-8477

Patient Name: PHN:

Date of Birth: Phone:

Please choose one option:

☐ See patient directly for iron infusion
☐ Provide assessment and create treatment plan for iron infusion

Laboratory Findings:

Iron studies:

☐ Iron study (within the last 3 months) attached

OR

HgB: Date:

Ferritin: Date:

Transferrin Saturation (if performed): Date:

Relevant Medical History:

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

If yes, please explain:

Does the patient have asthma or inflammatory arthritis? ☐ Yes ☐ No

Other allergies:

Is the patient pregnant? ☐ Yes ☐ No

Any additional clinical history / notes:

Orders:

☐ Monoferric 1000 mg
☐ Monoferric 500 mg
☐ Iron Sucrose (Venofer) x 300 mg infusion(s)
☐ This referral can also serve as a prescription. Please provide your consent for our pharmacist to manage and adjust prescription as needed including completing any special authorization forms.

☐ Repeat transfusions as appropriate up to per year

Physician Name: PRAC ID#:

Clinic Phone: Date:

Physician Signature:

Aeon Future Health 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. Full payment for all iron infusions is required at first appointment.