Iron Infusion / Consultation Referral Form

AEON FUTURE HEALTH

Email: admin@aeonfuturehealth.com OR Fax: 403-517-7666 Tel: 403-454-8477

PLEASE CHOOSE ONE OPTION:

☐ Iron Consultation Prior to Possible Infusion

☐ Iron IV Infusion (Accept this referral as a Prescription)

- ☐ Monoferric 1000mg ☐ Monoferric 500mg
- ☐ Iron sucrose (Venofer) 300mg infusion(s) x _____ times
- ☐ Repeat transfusions as appropriate up to _____ per year

PATIENT INFORMATION:

First Name: _____ Date of Birth: _____

Last Name: _____ PHN: _____

Email: _____ Phone: _____

CLINICAL INDICATION FOR REFERRAL:

☐ Iron Deficiency Anemia
☐ Heavy Menstrual Bleeding
☐ GI Malabsorption (e.g., celiac, IBD)
☐ Iron Deficiency without Anemia
☐ Postpartum
☐ Chronic Kidney Disease
☐ Other: _____

RELEVANT MEDICAL HISTORY:

Labs within the last 3 months. (Please attach additional pages or labs as necessary).

- Hemoglobin (Hg): _____ Date: _____ • Ferritin: _____ Date: _____
- Transferrin Saturation: _____ Date: _____
- CRP (if available): _____
- Past iron infusions? ☐Yes. ☐No. If yes, details: _____
- History of anaphylaxis or infusion reactions? ☐Yes. ☐No.
- Weight: _____
- Pregnancy status: ☐Not Pregnant ☐Pregnant ☐Breastfeeding
- Known medication allergies: _____
- Current medications (esp. anticoagulants, antihistamines):

_____

REFERRING PROVIDER INFORMATION:

Name: _____ Practice ID: _____

Clinic: _____ Phone: _____ Fax: _____

Signature: _____ Date: _____

Preferred Follow-Up:

☐ Refer back to me after consult/infusion
☐ Shared care (ongoing management support)
☐ I would like to be updated with treatment outcome

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.