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
- □ Monoferric 1500mg (completed in 2 separate infusions)
- □ Iron sucrose (Venofer) 300mg infusion(s) x _____ weekly
- □ Repeat transfusions as appropriate up to _____ per year

PATIENT INFORMATION:

First Name: _____ Date of Birth: _____

Last Name: _____ PHN: _____

Email: _____ Phone: _____

RELEVANT MEDICAL HISTORY:

☐ Patient has had relevant bloodwork* completed within the last 3 months.
*Includes: CBC, Ferritin, Iron Panel (T-sat), Hgb.

- Past iron infusions? □ Yes. □ No. If yes, details: _____
- Pregnancy status: □ Not Pregnant □ Pregnant □ Breastfeeding
- Known medication allergies: _____
- Current medications (esp. anticoagulants, antihistamines):

_____

REFERRING PROVIDER INFORMATION:

Clinic: _____ Practice ID: _____

Practitioner Name: _____ Date: _____

Phone: _____ Fax: _____ Signature:

Preferred Follow-Up:

☐ Refer back to me after infusion

☐ Shared care (ongoing management support)

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.