

# JPD WELLNESS – IRON INFUSION REFERRAL FORM

Provider: Beirut Van Het Hof, MSN, NP-PHC



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PLEASE FAX OR EMAIL COMPLETED FORM WITH LAB RESULTS (WITHIN 8 WEEKS)

<b>1. PATIENT INFORMATION</b> Name: _____ DOB (yyyy/mm/dd): _____ OHIP #: _____ Address: _____ _____ Phone (REQUIRED): _____ Allergies: _____	<b>2. REFERRAL INDICATION (Iron)</b> Iron Deficiency Anemia Iron Deficiency (no anemia) Intolerance to oral iron Malabsorption (IBD, bariatric, etc.) Chronic blood loss (specify): _____ Other (specify): _____		
<b>3. LAB REQUIREMENTS (WITHIN 8 WEEKS)</b> <table style="width:100%;"> <tr> <td style="width:50%;"> <b>REQUIRED:</b>                      Hemoglobin: _____ g/L                      Ferritin: _____ µg/L                      TSat: _____ %                      Date of labs: _____                 </td> <td style="width:50%;"> <b>RECOMMENDED:</b>                      CRP                      Vitamin B12                      Folate                      Creatinine / eGFR                 </td> </tr> </table> <p style="text-align: center;">Please attach copy of all available lab results.</p>	<b>REQUIRED:</b> Hemoglobin: _____ g/L Ferritin: _____ µg/L TSat: _____ % Date of labs: _____	<b>RECOMMENDED:</b> CRP Vitamin B12 Folate Creatinine / eGFR	<b>4. CLINICAL SCREENING</b> <input type="checkbox"/> No known hypersensitivity to IV iron <input type="checkbox"/> No active infection <input type="checkbox"/> No known iron overload disorder (e.g., hemochromatosis) <input type="checkbox"/> No significant liver disease Pregnant or trying to conceive: Yes <input type="checkbox"/> No <input type="checkbox"/> Patient Weight: _____ kg or lbs
<b>REQUIRED:</b> Hemoglobin: _____ g/L Ferritin: _____ µg/L TSat: _____ % Date of labs: _____	<b>RECOMMENDED:</b> CRP Vitamin B12 Folate Creatinine / eGFR		
<b>5. ROUTINE / URGENT</b> <input type="checkbox"/> Routine <input type="checkbox"/> Urgent (reason): _____ _____	<b>6. MEDICATION &amp; PHARMACY</b> Product: Monoferic® (ferric derisomaltose) ONLY Pharmacy Selection: <b>Provincial Road Pharmacy (Default)</b> <b>519-972-8788 Fax: 519-972-5637</b> Other pharmacy (name & phone): _____		
<b>7. COST &amp; COVERAGE (PATIENT MUST BE INFORMED)</b> <ul style="list-style-type: none"> <li>• Infusion fee: <b>\$175</b> (not covered by OHIP or private insurance)</li> <li>• The infusion fee is separate from the cost of the iron medication</li> <li>• Monoferic is usually covered by prescription insurance, but the patient is responsible for the full cost if it is not covered. The patient must contact the pharmacy to confirm coverage and discuss any out-of-pocket medication cost before booking.</li> </ul> <p>Referring provider confirms patient has been informed of the patient</p>	<b>8. ALTERNATE CARE CONSIDERATION</b> Patients with: <ul style="list-style-type: none"> <li>• Hgb &lt; 100 g/L AND</li> <li>• Ferritin &lt; 25 µg/L</li> </ul> May qualify for hospital-based infusion at WRH – Medical Day Care. Please consider referring eligible patients.		
<b>9. REFERRING PROVIDER INFORMATION</b> Provider Name (print): _____ Contact Phone #: _____ Provider Signature: _____ Date (yyyy/mm/dd): _____			
<b>10. OPTIONAL: PRESCRIPTION TEMPLATE</b> (If referring provider sends RX directly) <table style="width:100%;"> <tr> <td style="width:50%;"> <b>Medication:</b> Monoferic® (ferric derisomaltose)  <b>Dose:</b> 1000 mg IV x 1 dose  <b>Route:</b> Intravenous infusion  <b>Instructions:</b> To be infused in clinic by Nurse Practitioner Beirut Van Het Hof  <b>Indication:</b> Iron deficiency (as per clinical assessment and labs)                 </td> <td style="width:50%;"> <b>Dispense:</b> 1 vial (1000 mg)  <b>Refills:</b> 0  <b>Additional Instructions:</b>                      Patient to pick up medication from pharmacy and bring to scheduled infusion appointment.                 </td> </tr> </table> <p style="text-align: center;">Please send prescription to the pharmacy selected above unless otherwise directed by patient.</p>		<b>Medication:</b> Monoferic® (ferric derisomaltose) <b>Dose:</b> 1000 mg IV x 1 dose <b>Route:</b> Intravenous infusion <b>Instructions:</b> To be infused in clinic by Nurse Practitioner Beirut Van Het Hof <b>Indication:</b> Iron deficiency (as per clinical assessment and labs)	<b>Dispense:</b> 1 vial (1000 mg) <b>Refills:</b> 0 <b>Additional Instructions:</b> Patient to pick up medication from pharmacy and bring to scheduled infusion appointment.
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Patient must pick up medication prior to appointment and bring it to the clinic.

<b>FOR CLINIC USE ONLY</b>			
Reviewed by NP: _____	Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No	Planned Dose: <b>500 mg or 1000 mg</b> Monoferic	Appt Date: _____
Notes: _____			