Iron Infusion Therapy Referral Form:

Serenity Health charges for the infusion treatment. Please have patients check their extended insurance coverage if they are planning on claiming the cost to their insurance plan.

Section 1: Patient information

Patient name: _____ Patient DOB: _____

Patient: PHN: _____ Patient phone number: _____

Is this patient pregnant? Y / N

Has this patient received an iron infusion in the past? Y / N

- If yes, what was the iron prescription used: _____

Patient allergies:

- Medication allergies: _____
- Anaphylactic: _____
- Non-anaphylactic reaction: _____
- None: _____

Section 2: Laboratory information - *please include a copy of relevant bloodwork completed within the last 90days*

Date of bloodwork:

Hbg (g/L): _____ Ferritin (ug/L): _____

TSAT (%): _____

Section 3: Referring physician information

Clinic name:_____

Clinic phone number:_____ Clinic fax number:_____

Physician name:_____ Physician signature: _____

Date:_____

Please submit form to Serenity Health Clinic
Fax (604) 492-0816 or Email info@serenityhealthclinic.com

Thank you for your referral!

Serenity Health Clinic
22-2662 Austin Avenue, Coquitlam, BC V3K 6C4
Tel: (604) 492-0815 Fax: (604) 492-0816
info@serenityhealthclinic.com