SEASHELL MEDICAL
1927 Ironoak Way, Oakville, ON, L6H 3V7
P: (647) 227-8252 | F: (905) 636-9388

IRON IV REFERRAL FORM

PATIENT INFORMATION

Full Name: _____ Date of Birth: _____

Phone #: _____ Email Address: _____

Address: _____ City: _____ Province: _____

Postal Code: _____ HCN with VC: _____

Hb (g/L): _____ Ferritin (ng/L): _____ Date of Last Blood Test: _____

Weight (kg): _____ Allergies/ Pertinent Medical Info: _____

Pregnant: ☐ Y ☐ N Recent Blood Test Attached: ☐ Y ☐ N

PRESCRIBED MEDICATION

☐ **Monoferric (ferric derisomaltose)**

Dosage: _____ Number of Infusions: _____

☐ **Venofer (iron sucrose)**

Dosage: _____ Number of Infusions: _____

REFERRING PHYSICIAN INFORMATION

Physician's Name: _____ License #: _____ OHIP #: _____

Clinic Name: _____ Address: _____

City: _____ Province: _____ Postal Code: _____

Clinic Phone #: _____ Clinic Fax #: _____ Clinic Email: _____

I hereby delegate Dr. Omar Rafai, ND to administer intravenous iron infusion to the patient mentioned above. I understand that the procedure will be carried out in accordance with established medical protocols and safety standards, and the patient has provided consent to share pertinent laboratory results with the delegate upon request.

Physician's Signature: _____ Date: _____

Please email completed forms to info@valuintegrativehealth.com