POLO
HEALTH + LONGEVITY CENTRE

INFUSION REFERRAL FORM

Patient Name: _____ PHN: _____

Date of Birth: _____ Phone Number: _____
(MM / DD / YYYY)
Patients will be called by Polo Health Staff to arrange your appointment time

SECTION A IRON INFUSION

Indication: Iron deficiency +/- anemia **AND** oral iron replacement therapy ineffective.

LABORATORY

Please fax most recent relevant bloodwork and fill in the following:

Hgb: _____ Date: _____

Ferritin: _____ Date: _____

Transferrin Saturation: _____ Date: _____

ALLERGIES

Has the patient ever had an infusion reaction to iron in the past? ☐ Yes ☐ No

If yes, please explain: _____

_____

Does the patient have asthma/inflammatory arthritis? ☐ Yes ☐ No

Other Allergies: _____

_____

ORDERS

☐ Monoferric 1000mg ☐ Iron Sucrose ☐ Other: _____

☐ Monoferric 500mg _____ x 250mg Infusion(s)

IS THE PATIENT PREGNANT?

☐ Yes ☐ No

Clinic Name/ Phone Number or Stamp:

Physician Name: _____

Physician Signature: _____ Date: _____ _____

Polo Health + Longevity Centre 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.

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