THE LONGEVITY LAB

Iron Infusion Referral Form

Email address: hello@longevitylab.clinic
Fax: (825) 632 - 2616
Phone: (825) 540 - 8286

Patient Name: _____ Personal Health Number: _____

Date of Birth: _____ Phone Number: _____
YYYY/MM/DD

Indication for Infusion: _____

Laboratory Findings:

Include relevant bloodwork within the last 3 months or fill in the relevant information below

Hemoglobin: _____ Date: _____

Ferritin: _____ Date: _____

Iron: _____ Date: _____

Transferrin Saturation: _____ Date: _____

Medical History:

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

If yes, please explain: _____

List of all known allergies: _____

Does the patient have anxiety, asthma, eczema, mastocytosis, severe respiratory or cardiac disease, or systemic inflammatory disease? ○ Yes ○ No

Is the patient pregnant? ○ Yes ○ No

Additional Clinical History & Notes: _____

Order:

○ Iron Isomaltoside (Monoferric) _____ mg x _____ infusion (s) every _____

○ Iron Sucrose (Venofer) _____ mg x _____ infusion (s) every _____

○ This referral serves as a prescription. By providing your consent, you authorize the pharmacist at the patient's chosen pharmacy to make necessary adjustments and complete any required special authorization forms related to your prescription.

Provider Name: _____ Practitioner ID: _____

Provider Signature: _____ Clinic Name: _____

Date: _____ Phone Number: _____

An infusion fee applies for each treatment at The Longevity Lab. Patients should verify coverage with their insurance provider before their appointment. Payment in full for all iron infusions is required at the initial appointment.