Med Square Medical Center
www.WESNHealth.com
Phone 905-808-3002 Fax 1-888-890-9293
E-mail: Medsquare@wesnhealth.com

Iron Infusion Clinic

Patient information:

First name: _____ Last name: _____ DOB: _____ Gender: _____

Address: _____

Health Card # _____ Email: _____

Home Phone: _____ Cell: _____

Referral to: Iron Infusion Clinic

Urgency: ☐ Routine Referral ☐ Urgent Referral

Reason for referral:

☐ Oral Iron Intolerance ☐ Malabsorption of Oral Iron. ☐ Pre-OP Anemia

☐ Heavy Menstrual Bleeding ☐ Other: _____

Preferred Iron Therapy: ☐ Venofer ☐ Monoferric ☐ Clinic to determine

Clinical Information:

Previous Iron Infusion Therapy: ☐ First Time ☐ Previously Received

Is this patient pregnant? ☐ Yes ☐ No ☐ Unknow

History of: ☐ CKD ☐ Heart Failure ☐ Inflammatory bowel disease ☐ Malignancy ☐ None

History of Allergy: ☐ Yes ☐ No (if Yes, what is reaction type _____)

Recent Lab results: Hb:_____ MCV:_____ Ferritin: _____ (or attached with referral)

Recent Lab results date: _____ **(Lab results must be within 3 months or less)**

Referring Physician:

Physician name: _____ Signature: _____

Clinic Phone: _____ Clinic Fax: _____ OHIP Billing # _____

Clinic email: _____ Date: _____

Clinic Name & Address: _____

I confirm that the patient has been informed of this referral, agrees to treatment, and consents to sharing clinical information with the infusion clinic.

Please fax the recent medications list, blood work results and any related medical documents

Patient will be notified with the Appointment details upon confirmation
Clinic Location: 4188 Living Arts Drive, Unit 5, Mississauga, ON, L5B 0H7