Dr. Joel Kailia, MD
MSP #27131

PATIENT REFERRAL FORM

For Iron Infusion Assessment

#305-2730 Commercial Drive
Vancouver, BC, V5N 5P4
604-336-2844 | 604-336-2845(f)

PHYSICIAN INFORMATION			
Referring Physician:		Phone:	Fax:
MSP Billing #:	Address:		
Family Physician:		Phone:	Fax:

PATIENT INFORMATION			
Last Name:	First:		Middle:
DOB:	PHN:		Sex: ☐ M ☐ F
Address:	City:	Province:	Postal Code:
Home Phone:	Cell:	Email:	

PATIENT MEDICAL HISTORY

INDICATION FOR IRON INFUSIONS

❑ Anemia	❑ Low hemoglobin	❑ Fatigue
❑ Low ferritin	❑ Anemia of chronic disease	❑ Autoimmune & malabsorption
❑ Fibromyalgia	❑ Thyroid disease	❑ Other: _____
❑ Mitochondrial dysfunction	❑ Failure on PO/IM iron	

CURRENT MEDS (PLEASE INCLUDE PRINTED COPY OF MED LIST FROM EMR)

❑ _____	❑ _____	❑ _____
❑ _____	❑ _____	❑ _____

CLINICALLY RELEVANT MEDICATION/ TREATMENT (CURRENT & PAST)

ABSOLUTE CONTRAINDICATIONS

❑ Iron overload	❑ Known Hypersensitivity to Venofer	

CAUTIONS & POSSIBLE CONTRAINDICATIONS (will be reviewed)

❑ Cardiovascular disease	❑ Pregnancy	❑ Acute or chronic active infections
❑ Hemochromatosis	❑ Inflammatory rheumatic conditions	❑ Hx of Hypotension
❑ Impaired liver function		

LABS ATTACHED

❑ CBC + diff (with hemoglobin)	❑ Total iron binding capacity (TIBC)	❑ Liver enzymes
❑ Ferritin	❑ Transferrin	❑ Other: _____
❑ Serum Iron	❑ Transferrin saturation	❑ Other: _____

OTHER RELEVANT MEDICAL HISTORY

I confirm ALL of the following (please check ALL boxes)

❑ I ensure that all other medical conditions remain under my care (or other specialists) and are stable.		

Physician Signature: _____ **MSP #:** _____ **Date:** _____

**Send x1 copy with patient or fax to: 604-336-2845 | Keep copy for prescribing physicians chart*