SWFL HEALTH & HYDRATION

P: (239) 719-2107
F: (239) 355-5257

IV Therapy: Iron Infusion

Referral Form

Patient Information:

Name: _____ Date of Birth: _____

Address: _____

City/ State/ Zip: _____

Cell: _____ Home: _____

Diagnosis(es): _____

_____

Referring Physician:

Provider name: _____

Clinic Name: _____

Address: _____

City/ State/ Zip: _____

Phone: _____ Fax: _____

Email: _____

IV Protocol:

Venofer (iron sucrose) dosage: ☐ 100mg ☐ 200mg

Duration: once a week for _____ week(s)

-Add mini IV Bag of Vitamin C 2000mg to preceed the Iron Infusion for added absorption ☐

**Labs recommended: CBC, Iron, Ferritin, TIBC, and Liver Enzymes*

Physician signature: _____ Date: _____

Please fax this form along with any lab work to this number :
239-355-5257