Savi Skin Clinic | By Dr. Naqvi
150 Nipissing Road
Milton, ON
L9T 5B3
Phone: (365)-877-1792
Fax: (855)-877-1792

Email: info@savi.clinic

Please fax the completed form: Ensure the patient's email address is included and that a prescription for Ferinject has been provided to the patient for pickup at their pharmacy

FERINJECT IV IRON REFERRAL FORM

We are pleased to announce that Savi Skin Clinic is now offering Ferinject IV Iron Infusions as part of our current services.

Referral & Booking Information:

- Each infusion session is $175 (medication must be purchased separately at a pharmacy).
- Once we receive your faxed referral, an email will be sent directly to your patient with the scheduled date and time. **Please ensure the patient's email address is included on the referral.**
- **A prescription for Ferinject must also be faxed to the patient's pharmacy and the patient must bring the medication with them to their appointment.**
- We recommend Guardian Nipissing GDN Pharmacy
    - Phone: 365-877-7666
    - **Fax: 365-877-8666**

Important Notes:

- Incomplete referrals will not be accepted.
- We are currently booking appointments within just one week, making this an ideal time for patients in need of treatment.
- If the patient's hemoglobin (Hgb) is below 80, please attach a copy of their most recent blood work.

Thank you for your referral. We look forward to providing safe and effective iron therapy for your patients.

Savi Skin Clinic | By Dr. Naqvi
150 Nipissing Road
Milton, ON
L9T 5B3
Phone: (365)-877-1792
Fax: (855)-877-1792

Email: info@savi.clinic

Please fax the completed form: Ensure the patient's email address is included and that a prescription for Ferinject has been provided to the patient for pickup at their pharmacy

FERINJECT IV IRON REFERRAL FORM

PATIENT INFORMATION (Fill out patient information or affix patient label)

Full name: _____Date of birth (DD/MM/YYYY):_____
Address: _____City: _____ Province: _____ Postal code: _____
Preferred phone: _____ Alternate phone: _____ **Email**: _____
Health Card #: _____ Allergies: _____
Emergency Contact Name: _____Emergency Contact Phone: _____

PRESCRIPTION INFORMATION

Diagnosis: _____ Hemoglobin: _____g/L Ferritin: _____ng/mL
TSAT (if applicable): _____; Patient weight: _____lbs _____kg Date of weight: _____

Pregnant? ❒ Yes ❒ No
New to Iron Infusions? ❒ Yes ❒ No If no, indicate reaction details, if applicable:
_____

MEDICATION

❒ **Ferinject** Maximum dose for treatment: 15mg/kg | 1000mg per infusion. Treatment dose will be split according to bodyweight.

Pregnancy: Maximum cumulative dose (gestation week ≥16) is restricted to 1000mg for patients with Hb >90g/L or 1500mg in patients with Hb≤90g/L.

Hb (g/L)	Bodyweight <35 kg	Bodyweight 35 kg to <70 kg	Bodyweight ≥70 kg
< 100	❒ 500 mg	❒ 1500 mg	❒ 2000 mg
100 to <140	❒ 500 mg	❒ 1000 mg	❒ 1500 mg
≥140	❒ 500 mg	❒ 500 mg	❒ 500 mg

PRESCRIBER INFORMATION

Prescriber name: _____ License # _____
Address: _____ City: _____ Province: _____ Postal code: _____
Contact name: _____ Phone: _____
Fax: _____ Email: _____
Prescriber Signature: _____ Date: _____