

## **REFERRAL FOR TREATMENT WITH INTRAVENOUS IRON**

Patient name

Patient DOB

Patient hospital number

Name of referring physician

Contact number (bleep/secretary)

Recent blood results

Date			
Hb			
Hct			
MCV			
MCH			
Iron			
Transferrin			
Transferrin saturation			
Ferritin			
<b>Weight (kg)</b>			

Has iron deficiency been investigated? Yes ☐ No ☐

Reason for iron deficiency if known -

Has the patient been given oral iron? Yes ☐ No ☐

Why is the patient being referred for IV iron?

Has the patient previously had IV iron? Yes ☐ No ☐

Other relevant information

Send referral to Frances Hinch– Transfusion Practitioner  
[frances.hinch@hinchingsbrooke.nhs.uk](mailto:frances.hinch@hinchingsbrooke.nhs.uk) or C/O Pathology office

**THE PATIENT WILL REMAIN UNDER THE CARE OF THE REFERRING PHYSICIAN**