

# IRON INFUSION CLINIC BOOKING FORM

Cromwell  
Hospital

To be completed by Consultant/GP/Pre-assessment clinic and  
emailed to: [Ironclinic@cromwellhospital.com](mailto:Ironclinic@cromwellhospital.com)

| Please indicate Referral Source:                                                                                        |                          |                                                                                                                                                                                |                          |
|-------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| Consultant                                                                                                              | <input type="checkbox"/> | GP                                                                                                                                                                             | <input type="checkbox"/> |
|                                                                                                                         |                          | Pre-operative Assessment Team                                                                                                                                                  | <input type="checkbox"/> |
| Patient details                                                                                                         |                          |                                                                                                                                                                                |                          |
| Title:                                                                                                                  |                          | Surname:                                                                                                                                                                       |                          |
|                                                                                                                         |                          | First name(s):                                                                                                                                                                 |                          |
| Patient correspondence address:                                                                                         |                          | DOB:                                                                                                                                                                           | Age:                     |
|                                                                                                                         |                          | MRN:                                                                                                                                                                           |                          |
|                                                                                                                         |                          | <input type="checkbox"/> Patient <b>has not</b> visited Cromwell before, need new MRN<br><input type="checkbox"/> Patient <b>has</b> visited Cromwell before but unsure of MRN |                          |
| Patient main contact number:                                                                                            |                          | Insurance <input type="checkbox"/>                                                                                                                                             |                          |
|                                                                                                                         |                          | Self-pay <input type="checkbox"/>                                                                                                                                              |                          |
| Patient alternative number:                                                                                             |                          | Membership / Policy Number:                                                                                                                                                    |                          |
| Patient email:                                                                                                          |                          | Cromwell Consultant patient under care of:                                                                                                                                     |                          |
| Patient preferred form of contact:                                                                                      |                          | Preferred site for treatment:                                                                                                                                                  |                          |
| <input type="checkbox"/> Telephone<br><input type="checkbox"/> Email<br><input type="checkbox"/> Post (not recommended) |                          | <input type="checkbox"/> Cromwell Hospital<br><input type="checkbox"/> London Medical                                                                                          |                          |
| Clinical Details                                                                                                        |                          |                                                                                                                                                                                |                          |
| Haemoglobin level (g/l):<br>(Definition of anaemia <130g/l)                                                             |                          | Is patient due to have surgery:                                                                                                                                                |                          |
| TSATS:                                                                                                                  |                          | Yes <input type="checkbox"/>                                                                                                                                                   |                          |
| Ferritin:                                                                                                               |                          | No <input type="checkbox"/>                                                                                                                                                    |                          |
| B12:                                                                                                                    |                          | If due to have Surgery                                                                                                                                                         |                          |
| Folate:                                                                                                                 |                          | Procedure:                                                                                                                                                                     |                          |
|                                                                                                                         |                          | Planned date of procedure:                                                                                                                                                     |                          |
| Relevant PMH (eg severe asthma, Liver disease, Inflammatory disease):                                                   |                          |                                                                                                                                                                                |                          |
| Allergies:                                                                                                              |                          | Weight:                                                                                                                                                                        |                          |
| Completed by:                                                                                                           |                          | Date:                                                                                                                                                                          |                          |

| To be completed by Iron Clinic                                                                                                                                                                                                      |                                                                                                                                                                                                                                                          |
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| <b>Patient meets criteria for Iron Clinic:</b><br><br>Yes <input type="checkbox"/><br><br>No <input type="checkbox"/><br><br><i>Please Note: If not suitable please contact, in writing, patient AND referrer decision and why.</i> | <b>For pre-operative patients:</b><br><br>Is request for Iron infusion >2 weeks from surgery: Yes <input type="checkbox"/> No <input type="checkbox"/><br><br><b>If no, please ensure that patient is considered for Iron infusion post-operatively.</b> |
| Any further blood tests to be requested before Iron Clinic:                                                                                                                                                                         | Date of Iron Clinic requested:                                                                                                                                                                                                                           |
| Site for Iron Clinic:<br><br><input type="checkbox"/> Cromwell Hospital<br><input type="checkbox"/> London Medical                                                                                                                  |                                                                                                                                                                                                                                                          |
| Completed by:                                                                                                                                                                                                                       | Date:                                                                                                                                                                                                                                                    |

Once Iron Clinic has filled in section, please send form to: [reservations@cromwellhospital.com](mailto:reservations@cromwellhospital.com)

Reservations Team:

Once patient has confirmed they are able to attend Iron Clinic please ensure they are booked into Compucare slot.

|                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p align="center"><b>Criteria for Iron Deficiency anaemia:</b></p> <p align="center">Hb &lt;130g/L and Ferritin &lt;30ng/ml</p> <p align="center"><b>Or</b></p> <p align="center">Hb &lt;130g/L, Ferritin 30-100ng/ml <b>and</b> TSAT &lt;20%</p> |
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