

Infusion General Referral

Patient Name:		Patient DOB:	
Patient Address:		Patient Phone:	
Parent/Guardian (if under 18):			

Clinical Information

Allergies:			
Pertinent Medical History:	p Pregnant (Gestation in weeks _____) p Fluid Restriction _____		
Height:	cm	Weight:	kg
Haemoglobin:		Ferritin:	p N/A

Infusion Order**REFERRING DOCTOR TO PLEASE ISSUE A SCRIPT TO PATIENT FOR MEDICATION TO BRING TO APPOINTMENT**

p Ferinject® _____ mg (choose 500 mg, 1000 mg) (Higher doses can be given in divided doses 1 week apart)

p Paediatric Ferinject® _____ mg (Not to exceed 20mg/kg and maximum 1000mg)

p Aclasta® _____ mg infusion

p 0.9% Sodium Chloride _____ mL over _____ min

p Stemetil _____ mg

p Maxalon _____ mg

p Other (please include dose and rate of infusion) _____

I have reviewed risks, benefits, side effects and alternatives to the procedure with the patient (parent/guardian) and can verify that they have consented to the above procedure and treatment plan. The patient understands they may withdraw consent at any time.

Referring Doctor

NAME: _____	PROVIDER: _____
ADDRESS: _____	
DOCTOR'S SIGNATURE: _____	DATE: _____