

Referral for Iron Infusion Clinic

Blackbutt Doctors Surgery
Level 1/58 Orchardtown Rd
New Lambton NSW 2305
Ph: 49509733 Fax: 49529708
ABN: 63138348928

Date:

Dear Dr Rochelle Grainger

Patient Details:

Name:
DOB:
Address:
Contact Number:

I am referring my patient to your clinic for a 1g infusion of Ferinject.

Fe studies (no more than 4 weeks old):

Hgb (no more than 4 weeks old):

Patient is more than 14 years of age.

If patient of female and of child-bearing age, I have ascertained that she is not currently pregnant.

I understand I am managing the iron deficiency and the clinic will simply provide an iron infusion.

I have provided the patient with a Ferinject script,(500mg x 2), which they will fill and bring with them on the day of the infusion.

I have provided the patient with a Ferinject CMI.

I have provided them with a pathology form, for a Hgb and Fe studies for 4 weeks post infusion date.

Past History:

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Current Medications:

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Allergies:

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Thank you for your care and assistance. I look forward to hearing the outcome of their attendance.

Yours sincerely

Doctor Name:
Provider Number:
Address:
Contact Phone:

Referring Doctor Stamp:

