



REFERRAL FORM

Email all Referrals to: info@sainfusion.com.au

OR Fax to: (08) 7081 7038

PREFERRED LOCATION

ST PETERS

KIDMAN PARK

PARA HILLS

PATIENT DETAILS

Name:

Address:

Date of Birth:

Contact Phone:

REFERRER DETAILS (or stamp)

Doctor Name:

Provider No.:

Practice:

Phone or Email:

*** If the referring GP or referring specialist is able to, we kindly request they provide the script for the IV iron medication to the patient at the time of referral, for the patient's convenience. If not, we can arrange for the script to be written on the day of their appointment.*

TO BE COMPLETED BY GP / REFERRER

I am including the essential clinical information required for triage and calculation of total iron requirement as described below.

Pathology results attached: FBC, iron studies, LFTs — PREFERABLY DONE WITHIN LAST 4 WEEKS

Tick the criteria they meet below (select ANY that apply):

Hb \leq 100 g/L OR Ferritin \leq 30 μ g/L

Ferritin \leq 100 μ g/L with transferrin saturation $<$ 15%

Symptoms of iron deficiency AND Ferritin \leq 50 μ g/L

Is the patient pregnant?

Yes

No

Age:

Patient age \geq 14 years old (SA Infusion Services only provides iron infusions to non-pregnant patients, aged 14 or above.)

Weight (kg):

Allergies, including previous allergic reaction to intravenous iron:

PLEASE NOTE

By signing this referral form, the referrer fully accepts & acknowledges that investigation of the underlying cause(s) of the patient's iron deficiency, and treatment of these causes, are NOT the responsibility of SA Infusion Services and solely remain the referrer's responsibility. Referrer to consider a separate referral to appropriate specialty if required. Referrer also accepts it is their responsibility to follow up results of the iron studies to be performed 6 weeks after the iron infusion.

Referrer MUST also advise patient on plan with oral iron supplementation if currently being taken (general advice would be to stop oral iron 7 days prior to the iron infusion and for 5 days after the infusion). **If patient is younger than the age of 18, they must present with a parent or guardian.**

Date:

GP / Referrer Signature: _____