SA Infusion Services

REFERRAL FORM

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

OR Fax to: (08) 7081 7038

PATIENT DETAILS

Full Name: _____

Address: _____

Date of Birth: _____

Contact Phone: _____

REFERRER DETAILS (or stamp)

Full Name: _____

Provider No.: _____

Practice: _____

Fax or Email: _____

**** If the referring practitioner 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.

DETAILS OF REFERRAL

☐ I have attached the required pathology results — CBE, LFTs & Iron Studies **(performed within the last 6 weeks)**

Tick the criteria the patient meets below (select ANY that apply):

☐ Hb ≤100 g/L or ☐ Ferritin ≤30 µg/L

☐ Ferritin ≤100 µg/L with transferrin saturation <15%

☐ Symptoms of iron deficiency AND Ferritin ≤50 µg/L

Is the patient pregnant?

○ Yes ○ No

Age: _____

(SA Infusion Services is only able to accept referrals for non-pregnant patients, aged 14 or older)

Weight (kg): _____

Allergies (& any previous reactions or adverse effects after administration of intravenous iron):

REFERRER ACKNOWLEDGEMENT

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 also accepts it is their responsibility to follow-up results of the iron studies blood test to be performed typically 6 to 8 weeks after the iron infusion.

Referrer MUST also provide the patient with instructions for oral iron supplementation if currently being taken. **If the patient is younger than the age of 18, they must present with a parent or guardian.**

Date: _____ Referrer Signature: _____