



GENREF 0100

SEND REFERRAL HealthLink: Email: infusionclinic@topdoc.au Fax: (02) 8551 9288

MORE INFORMATION 02 8551 9300 OR SCAN ME [QR Code]

PATIENT DETAILS SURNAME: GIVEN NAMES: DOB: SEX: M F Other AFFIX PATIENT LABEL IF AVAILABLE

Patient Contact Details Patient Clinical Details

PHONE: EMAIL:

DIAGNOSIS / INDICATION FOR INFUSION: CLINICAL PARAMETERS: Weight Hb eGFR CREAT Ferritin Corr Ca

Emergency Contact Details

NAME: PHONE: RELATIONSHIP:

ALLERGIES: MEDICAL HISTORY: Drugs Previous Infusion Reaction Latex NONE Other: Pregnant Gestation In weeks Heart Failure Renal Failure Liver Failure NONE Other:

Medical Infusion

Iron Infusion MEDICATION: Ferinject Monofer DOSAGE: 500 mg 1000 mg 1500 mg 2000 mg PLEASE NOTE: Refer to simplified dosing table or use Ganzoni formula... SIMPLIFIED DOSING TABLE: Hb (g/L) Weight 35-70 kg Weight >=70 kg

Bone Health Infusion Hydration Infusion MEDICATION/DOSAGE: Zoledronic Acid 5mg SPECIAL INSTRUCTIONS: DILUTION/DURATION TYPE: Saline 0.9% Hartmanns Solution VOLUME: 500 mL 1 L 2 L SPECIAL INSTRUCTIONS: DURATION/TREATMENT SCHEDULE

Antibiotic Infusion MEDICATION/DOSAGE: Cefazolin 1g 2g Ceftriaxone 1g 2g Clindamycin 0.6g 0.15g PLEASE NOTE: Medications will be given as a single dose unless a repeat dosing schedule is clearly prescribed. SPECIAL INSTRUCTIONS: DILUTION/DURATION/TREATMENT SCHEDULE

Other Treatments / Pre-medication / Venesection PROCEDURE TYPE: Medication Pre-medication Venesection MEDICATION / DOSAGE: DRUG/ DOSE / INTERVENTION INSTRUCTIONS: ROUTE / DILUTION/ DURATION SELECT IF APPLICABLE: Single Dose Multi Dose As Needed (PRN)

Referring Doctor Signature & Patient Consent

DOCTOR NAME: PROVIDER NO: PHONE NO: PRACTICE NAME: AS THE PRESCRIBING DOCTOR, I CONFIRM THE FOLLOWING: I have explained the purpose, risks, and side effects of this treatment. The patient understands they may withdraw consent at any time. The patient has no known contraindications and I have provided a valid prescription, along with relevant blood results or supporting clinical documentation (where applicable). DOCTOR'S SIGNATURE: DATE:

DO NOT WRITE IN THIS BINDING MARGIN

REFERRAL AND CONSENT FOR PROCEDURE