SPLREF 0100

TopDoc InfusiOn clinic

Specialist Medical Infusion Referral & Consent for Procedure

SEND REFERRAL

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

MORE INFORMATION

02 8551 9300
OR SCAN ME ⟶

PATIENT DETAILS

SURNAME: ....

GIVEN NAMES: ....

DOB: .... SEX: ☐ M ☐ F ☐ Other

AFFIX PATIENT LABLE IF AVAILABLE

www.topdocinfusionclinic.com.au

Patient Contact Details

PHONE: ....

EMAIL: ....

Emergency Contact Detials

NAME: ....

PHONE: ....

RELATIONSHIP: ....

....

Patient Clinical Details

DIAGNOSIS / INDICATION FOR INFUSION:

....

....

CLINICAL PARAMETERS:

Weight .... Hb .... eGFR ....

CREAT .... Ferritin .... Corr Ca ....

ALLERGIES:

☐ Drugs ⟶ *Specify* ....

☐ Previous Infusion Reaction

☐ Latex ☐ NONE

☐ Other: ....

MEDICAL HISTORY:

☐ Pregnant ⟶ *Gestation In weeks* ....

☐ Heart Failure ☐ Renal Failure

☐ Liver Failure ☐ NONE

☐ Other: ....

DO NOT WRITE IN THIS BINDING MARGIN

Medical Infusion

Biologic Infusion

mAb	BRAND	
Infliximab	☐ Remicade®	☐ Inflectra®
	☐ Renflexis®	
Vedolizumab	☐ Entyvio®	
Ustekinumab	☐ Stelara®	☐ Uteknix®
Natalizumab	☐ Tysabri®	
Tocilizumab	☐ Actemra®	
Eptinezumab	☐ Vyepti®	
Ocrelizumab	☐ Ocrevus®	
....	☐	

INSTRUCTIONS

☐ Induction ☐ Maintenance

DOSE/ ROUTE (IV,SC)/ DILUTION/ DURATION - *Eg: 5mg/kg IV in 250ml NS over 2 hours*

TREATMENT SCHEDULE - *Eg: Once every 4 weeks for 12 weeks*
(PLEASE ISSUE A VALID SCRIPT WITH SUFFICIENT REPEATS)

SPECIAL INSTRUCTIONS - *Eg: Fluid Restriction*

Intralipid Infusion (Intravenous)

STANDARD PROTOCOL

☐ 100 ml of Intralipid 20%

Diluent: *500 ml Normal Saline 0.9%*

Duration: *2 hour infusion*

ALTERNATE PROTOCOL

☐ Volume: .... of Intralipid 20%

Diluent: ....

Duration: ....

TREATMENT (T) SCHEDULE

☐ T1 Date ....

☐ T2 Date ....

☐ T3 Date ....

Pre-medication

MEDICATION/ DOSE

☐ Hydrocortisone 50mg IV ☐ Methylprednisolone 100mg IV ☐ Paracetamol 1g PO ☐ NONE

☐ Hydrocortisone 100mg IV ☐ Cetirizine / Loratadine 10mg PO ☐ Other: ....

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: ....

REFERRAL AND CONSENT FOR PROCEDURE

20/07/25 SPECILIST REFERAL Ver 1.00

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PATIENT INFORMATION TURN PAGE