appletree family practice

Iron Infusion Clinic

Referral form

URGENT/ ROUTINE

Patient Details

First name: _____

Surname: _____

DOB: _____

Address: _____

Phone No: _____

Previous Infusion:

Yes Date of previous infusion ___/___/____

No If no, is patient taking or has patient tried oral iron Yes / No

Previous reaction to an IV iron preperation Yes / No

Comment on nature of reaction: _____

The following information **must** be sent with this referral:

- Medical History
- UEC/FBE/iron studies/results within 4 weeks of referral date
- Results of Relevant Clinical Investigations

As the referring doctor I confirm that:

- Patient is > 18 yrs of age
- There is evidence of intolerance/lack of efficacy/malabsorbtion of oral iron
- Patient is not in the 1st trimester of pregnancy
- There are no known contraindications to iron infusion for this patient

I understand that Appletree Family Practice will provide the iron infusion service. The referring doctor is responsible for ongoing investigations, follow up and care of the patient.

Referrer's Name: _____ Signature:_____ Referral Date: ___/___/____

Referring Doctor (stamp)

Name:

Provider No:

Address:

Phone:

Fax:

Ph: 02 4922 6400
Fax: 02 4920 9073
Address: 2/20 Smith Street, Charlestown, NSW
Email: info@appletreefamilypractice.com.au

Please fax/email completed referral and above information to 0249209073