INFUSION HEALTHCARE
0800 2 INFUSE (0800 2 463873)
info@infusionhealthcare.nz
www.infusionhealthcare.nz

Please note this referral is for the administration of therapy only. This does not constitute a referral for investigation or other management.

PATIENT

Name: D.O.B: Phone:

CLINICAL INFORMATION

Allergies (please list):

WEIGHT: Hb: CREAT: eGFR: FERRITIN: TSAT: CRP:

Medical History: ☐ Pregnant (Gestation /40) ☐ Fluid Restriction ☐ Heart Failure ☐ Renal Failure

*** PLEASE ISSUE A VALID SCRIPT TO PATIENT FOR ALL REQUESTED DRUGS ***

GENERAL REFERRAL FORM FOR IV INFUSIONS

IRON ORDER

- ☐ Ferinject 500mg (1 vial)
- ☐ Ferinject 1000mg (2 vials)
  DO NOT ADMINISTER MORE THAN 1000MG OF IRON PER WEEK.
- ☐ Ferinject 1500mg
- ☐ Ferinject 2000mg

Dose Calculator for Intravenous Iron

Hb g/L	Body Weight 35 to <70kg	Body Weight ≥ 70kg
<100	1500mg	2000mg
≥100	1000mg	1500mg

INTRAVENOUS FLUID ORDER

TYPE:
- ☐ Normal Saline 0.9%
- ☐ Hartmanns
- ☐ Other .....

VOLUME:
- ☐ 500mL
- ☐ 1L
- ☐ 2L

RATE/DURATION:
.....
.....

INTRAVENOUS MEDICATION ORDER (eg. Bone health infusions, Antibiotics or Antiemetics)

Date	Medication and Strength	Dose, Route, Frequency, Instructions	Prescriber Signature

Referring Doctor (Doctor's Signature essential for valid order)

Name ..... Provider No. .....

Address .....

Doctor's Signature ..... Date .....

Administered by Infusion Healthcare Registered Nurse

Name ..... Registration No. .....

Signature ..... Date ..... Time Given .....