Peninsula Health
Infusion Centre

REFERRAL
IRON INFUSION /
BLOOD TRANSFUSION

Peninsula Health Use Only →

UR NUMBER ....

SURNAME ....

GIVEN NAMES ....

DATE OF BIRTH .... Gender ....
Please fill in if no Patient Label available

Rev.27/04/18 Print Code:17049

Referral to: ***Dr. Anmol Bassi***

Fax referral and all results to:

Infusion Centre
Frankston Hospital
Frankston VIC 3199
Phone: 9788 1710
Fax: 9784 2333

Referring Doctor (Stamp):
Referring Doctor's Name
Provider Number
Address

Telephone Number

PATIENT DETAILS

Title:........... Given Names: ....Surname: ....

Patient Address: ....

Preferred Contact Number: .... Date of Birth: ..../......../........

Medicare Card No.............................. Spoken Language:...................... Interpreter Required: ☐ Yes ☐ No

Please select Treatment request and complete Medical History below

Iron Infusion ☐
URGENT ☐ **ROUTINE** ☐
Previous infusion: ☐ Yes **Date of previous Infusion:** ..../.........../...........
☐ No **If no, is patient taking or has patient tried oral iron** ☐ Yes ☐ No
☐ **Previous reaction to IV iron preparation - comment on nature of reaction:**
....

Blood Transfusion ☐
URGENT(eg HB < 8) ☐ **ROUTINE** ☐
Previous infusion: ☐ Yes **Date of previous Infusion:** ..../.........../...........
☐ No

Medical Diagnosis for Required Treatment: ....
....

Medical History: *Note: FBE/ iron studies/ results within **4 weeks** of referral date, must be sent with referral*
Please attach copy of UEC

Evidence of intolerance to oral iron	☐	Rapid iron repletion clinically important	☐
Evidence of non-compliance with oral iron	☐	Short time to non-deferrable surgery	☐
Evidence of lack of efficacy with oral iron	☐	Menorrhagia / Menstruation related issues	☐
Malabsorption (Gastric surgery, coeliac disease)	☐	Known vegetarian/vegan diet	☐
Haemoglobin less than 100 g/l and more than 70g/l*	☐		

....
....

Current weight (Within 4 weeks) ....

Allergies / Adverse reactions ....

Referrer's Name:..Signature.............................. Referral Date:..................

Please fax completed referral and any relevant results to 9784 2333

PH Infusion Centre Office Use Only

............./............./.............	............./............./.............	............./............./.............
Received	Screened	Triaged

27/04/18 Print Code:17049 Ref link / GP liaison / Allanbys

REFERRAL IRON INFUSION OR BLOOD TRANSFUSION

MR/352910