DOCTOR REFERRAL

PATIENT NAME: .....

DOB: ..... NHI: ..... Phone: .....

CLINICAL INFORMATION

Weight: ..... Allergies: .....

Medical History: ☐ Pregnant (Gestation in weeks .....) ☐ Liver Failure ☐ Heart Failure ☐ Renal Failure

Recent Bloods: ..... Date Taken: .....

IRON PRESCRIPTION (If more than Ferinject 1 g is required, this will be given in divided doses over two consecutive weeks)

☐ Ferinject 1 g
☐ Ferinject 1.5 g
☐ Iron Polymaltose

INTRAVENOUS MEDICATION ORDER

Antiemetics

☐ Maxalon 10 mg
☐ Stemetil 12.5 mg
☐ Ondanesetron ☐ 4 mg ☐ 8 mg

Antibiotics (order is for single dose unless otherwise specified)

☐ Cephazolin ☐ 0.5 g Q24H ☐ 1 g Q24H ☐ 2 g Q24H

☐ Gentamicin
3-6 mg/kg ideal weight, use lower end if CrCl<40 ml/min
Dose: .....

☐ Probenacid PO 1 g @ time of antibiotics
(If not contraindicated)

OTHER MEDICATION: .....

Please specify drug, dose, route, frequency, and duration. Please contact us to confirm this medication is available.

INTRAVENOUS FLUID ORDER TYPE

☐ Normal Saline 0.9%
☐ Plasmalyte

RATE/TIME: .....

VOLUME
☐ 500 ml
☐ 1 L
☐ 2 L

VENESECTION ORDER DRAW
☐ 450 ml Whole Blood (Standard)
☐ 250 ml Whole Blood
Order valid for 12 months

Frequency of venesections: .....

Number of venesections: .....

MIGRAINE/HEADACHE MANAGEMENT PRESCRIPTION

☐ Fluids (please specifiy under Intravenous Fluid Order)
☐ Stemetil 12.5 mg IV (may cause drowsiness)
☐ Paracetamol 1 g PO
Order valid for 12 months (PRN)

CONSENT (Patient MUST sign this consent in the presence of the referring doctor)

My medical practitioner and I have discussed my present condition(s) and the various ways in which it may be treated, including the above proposed procedure and/or treatment. The doctor has informed me and I understand:

- The procedure/treatment proposed
- The procedure/treatment carries some risks, and complications may occur, and
- Additional treatments may be needed to achieve the desired results.

I give permission for The Infusion Clinic to access my notes and any investigations related to my health and treatment. I understand that I may withdraw my consent. I request and consent to the procedure/treatment described above for me.

PATIENT'S SIGNATURE: ..... DATE: .....

REFERRING DOCTOR NAME: ..... NZMC No: .....

Address: .....

DOCTOR'S SIGNATURE: ..... DATE: .....

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