# Infusion Doctor Referral

ASpeC ACADEMIC SPECIALISTS CENTRE

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**PATIENT NAME:** .....

**DOB:** ..... **PHONE:** .....

*Office use only:*
**Overseeing Doctor:** .....
**Provider number:** .....

## CLINICAL INFORMATION

**ALLERGIES:** .....

**WEIGHT:** ..... **Hb:** ..... **CREAT:** ..... **eGFR:** ..... **FERRITIN:** .....

**MEDICAL HISTORY:** ☐ Pregnant ☐ Fluid Restriction ☐ Heart Failure ☐ Renal Failure

## IRON ORDER (Ferinject®)

****PLEASE ISSUE A VALID SCRIPT TO PATIENT****

Given in divided doses; maximum 1g administered per infusion – only 1 request form needed.

☐ **Ferinject 500mg** (1 vial) ☐ **Ferinject 1.5g** (3 vials – administered over 2 separate appointments)

☐ **Ferinject 1g** (2 vials) ☐ **Ferinject 2g** (4 vials – administered over 2 separate appointments)

**Simplified Dose Calculator for Ferinject®**
**Maximum Dose per Infusion is 1g (2 vials)**

| | Wt < 70kg | Wt ≥ 70kg |
|---|---|---|
| Hb < 100g/L | 1.5g (3 vials) | 2g (4 vials) |
| Hb ≥ 100g/L | 1g (2 vials) | 1.5g (3 vials) |

**PBS INDICATION:**

*Ferinject® is indicated for the treatment of iron deficiency when oral iron preparations are ineffective or cannot be used. The diagnoses must be based on laboratory tests. (PBS:500mg/ 10mlx2 +Rptx1)*

## INTRAVENOUS MEDICATION ORDER

**** PLEASE ISSUE A VALID SCRIPT TO PATIENT****

### ANTIEMETICS

☐ Maxalon® 10mg

☐ Stemetil® 12.5mg

☐ Ondansetron (non PBS) ☐ 4mg ☐ 8mg

### ANTISPASMODICS

☐ Buscopan 20mg

### ANTIBIOTICS

☐ Cephazoli ☐ 1g ☐ 2g

☐ Ceftriaxone 1g

☐ Ampicilli ☐ 1g ☐ 2g

☐ Gentamicin DOSE: _____
4-5/kg ideal weight, use lower end if CrCL<40ml/min

**OTHER:** _____

## INTRAVENOUS FLUID ORDER

**TYPE:** ☐ Normal Saline ☐ Hartmanns

**VOLUME:** ☐ 500mL ☐ 1000mL ☐ 2000mL

**RATE/TIME:** _____

## VENESECTION ORDER

**DRAW:** ☐ 450mL Whole blood (Standard) ☐ 250mL Whole Blood

**Frequency of venesections:** _____

**No. of venesections:** _____

## MIGRAINE/HEADACHE MANAGEMENT ORDER

☐ 10L/min $O_2$

☐ Fluids (Please specify under Intravenous Fluid Order)

☐ Stemetil® ☐ Paracetamol 1g PO

☐ Maxalon® ☐ Aspirin 900mg PO

☐ *Order Valid for 12 months*

## REFERRING DOCTOR

NAME: _____

ADDRESS: _____

_____

SIGNATURE: _____

PROVIDER No.: _____ DATE: _____

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