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: _____ NHI: _____

CLINICAL INFORMATION

ALLERGIES: _____

WEIGHT:_____ FERRITIN: _____ TSAT: _____

CRP: _____ Hb: _____

MEDICAL HISTORY: _____

Fluid Restriction: □

Heart Failure: □

Renal Failure: □

Have they had an Iron Infusion before? Yes No

If Yes? Did you tolerate it? Yes No

IRON ORDER

□ Ferinject 500mg (1 vial)

□ Ferinject 1000mg (2 vial)

DO NOT ADMINISTER MORE THAN 1000MG OF IRON PER WEEK

REFERRING DOCTOR (Doctor's Signature essential for valid order)

NAME: _____MCNZ Registration NO: _____

ADDRESS:_____

DOCTOR'S SIGNATURE: _____ DATE: _____

ADMINISTRATOR/REGISTERED NURSE

NAME: Sonia Halbert REGISTRATION NO: 186695

SIGNATURE:_____ DATE: _____ TIME GIVEN:_____