Peninsula Health
Infusion Centre

REFERRAL
BLOOD TRANSFUSION

Peninsula Health Use Only →

UR NUMBER .....

SURNAME .....

GIVEN NAMES .....

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

App.17/7/2024 Print Code:18558

PHF352911e

Please Note: Patients who are acutely unwell, haemodynamically compromised or have active uncontrolled bleeding or have a hb ≤ 70g/L with signs and symptoms of anaemia **CANNOT** be referred to the Infusion Centre.

Referring clinician details:

Name:

Practice Name:

Practice Address:

Provider number:

Phone number:

Fax number:

Signature:

Date of referral: ...../...../.....

Referral details:

Previous treatment in
Frankston Hospital Infusion Centre? ☐ Yes ☐ No

Is the patient currently under the care of
a Peninsula Health speciality unit?

☐ Yes, ... *(please specify unit)* ☐ No

PATIENT DETAILS

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

Gender: ..... DOB: ..... Contact number: .....

Address: .....

Medicare Card No.: ……..... [.....] Exp: ...../...../.....

If there is no Medicare card - please specify if patient has: ☐ *private health insurance cover* ☐ *self-funding treatment*

Spoken Language ☐ English Other *(please specify)* ..... Interpreter Required: ☐ Yes ☐ No

Will the patient arrive by ambulance / patient transport? Yes / No

Can the patient sit on a chair for treatment? Yes / No

Does the patient require assistance with ADLs Yes / No

If yes, will a carer be present Yes / No

Can the patient consent to treatment Yes / No

If no, please specify name, relationship and contact details of person responsible who will consent on patient's behalf

.....

CLINICAL INFORMATION

Please specify cause of patient's anaemia or please specify if further investigation is being undertaken to determine cause. .....

.....

Clinical indications for transfusion *(please specify signs and symptoms and target hb)*

.....

Please attach patient's health summary which includes current medical history, past medical history, current medication list and allergies. Please also include patient's advance care directive if available.

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PHF35291 1e

CLINICAL INFORMATION

Haemoglobin result ..... Date of test: ...../...../..... *(please attach pathology result)*

Please note:

FBE results should be within 2 weeks of referral date. Please also attach a copy of recent UEC, iron studies and other relevant pathology. If patient requires an iron infusion as well, please complete and attach a referral form for an iron infusion together with the referral for a blood transfusion.

Has a Dorevitch Pathology blood product request form requesting crossmatch been given to the patient / nursing home facility?

☐ Yes ☐ No

Note: Crossmatch **MUST BE** done by Dorevitch Pathology-no other pathology service can be accepted.

Please refer to the flowchart located on the Peninsula Health website (Infusion centre - Blood transfusion referrals) for the process for GP referrals of community based patients requiring a blood transfusion at the infusion centre .

INFUSION CENTRE MEDICAL STAFF TRIAGE

Date Received: ...../...../..... Date triaged: ...../...../.....

Triaged by .....

Referral accepted: Yes / No If no please specify reason .....

GP notified referral not accepted ? Yes / No

Referral returned to GP? Yes / No

INFUSION CENTRE

Infusion Centre Phone : 03 9788 1710. Fax: 03 9784 2333

Opening Hours: Monday – Friday 8am to 4.30pm

Closed weekends and Public Holidays

All referrals are to be faxed and include all the requested information above.

Please note incomplete referrals will NOT be accepted and will be returned to the referring doctor.