Peninsula Health
Infusion Centre

REFERRAL
IRON INFUSION

IC: M-F 0800 - 1630 service

Peninsula Health Use Only →

UR NUMBER .....

SURNAME .....

GIVEN NAMES .....

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

App.23/7/2024 Print Code:17049

PHF352910\

Infusion centre details:
Infusion centre -Frankston Hospital
Phone: 03 9788 1710
Fax: 03 9784 2333
Opening hours: Monday to Friday 8am to 4.30pm, closed on weekends and public holidays.
Please fax all referrals including results and patient's health summary to the above listed fax number
Incomplete referrals will not be accepted and returned to the referring doctor

Referring Doctor:
Name:
Practice Name:
Practice Address:
Provider number:
Phone number:
Fax number:
Signature:

Referral date: …….....…….

PATIENT DETAILS

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

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

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

REQUESTED TREATMENT:

☐ **URGENT IRON INFUSION (Hb < 100g/L but > 70g/L)**
Please provide FBE and iron studies within 2 weeks from referral date. **Note:** Please refer the patient to the nearest emergency department if hb ≤ 70g/L, patient is haemodynamically unstable, is acutely unwell or is actively bleeding.

☐ **SEMI - URGENT (Hb 101g/L to 109g/L)**
Has the patient been on at least 60-100mg elemental iron on an alternate day dosing but have not achieved an adequate haemoglobin rise (>10g/L) after 4 weeks? ☐ YES ☐ NO, if no please specify reason for referral: .....
Please provide FBE and iron study results (pathology test has to be within 4 weeks form referral date).

☐ **ROUTINE (HB ≥ 110g/L)**
Has the patient taken an adequate amount of oral iron therapy at least 60-100mg elemental iron on an alternate day dose for at least 12 weeks prior to referral for an iron infusion? ☐ Yes ☐ No, if no please commence on oral iron therapy / specify reason for immediate referral. .....
Please provide FBE and iron study results done prior to commencement of oral iron therapy and 12 weeks post commencement of oral iron therapy (Pathology test has to be within 4 weeks from referral date).

☐ Iron Deficiency ☐ Iron Deficiency Anaemia Specify the underlying Cause: .....
Cause being investigated further ☐ *(please tick if applicable)*

Please note that a referral for an iron infusion is not considered a request for investigation of the cause of iron deficiency.
Please direct referrals for further investigation to the relevant specialty clinic depending on clinical suspicion.

Date of previous iron infusion: ...../...../.....

Previous reaction to IV iron preparation ☐ Yes ☐ No

If yes, please comment on the type of iron preparation , the nature of the reaction and the medical management.

.....

Is the patient pregnant ? ☐ Yes Gestation ..... ☐ No

Allergies: .....

Has antiresorptive therapy (eg: denosumab) been administered in the last 4 weeks or is planned for administration in the next 4 weeks ☐ *Yes* ☐ *No*

Patient / NOK consented for referral to be sent ☐ Yes ☐ No

Side effects of IV iron including risk of permanent skin stain, anaphylaxis, flu-like symptoms, hypophosphatemia with certain iron preparations has been discussed with patient / NOK? ☐ *Yes* ☐ *No*

Please refer to the Peninsula Health Referral guidelines for an iron infusion for further information and referral criteria.

Please fax the completed referral, pathology results *(FBE, UEC, iron studies)* as well as other relevant pathology results and patient's current health summary to 03 9784 2333

PH Infusion Centre Office Use Only

Date received: ..... Triaged by: ..... Date Triaged: .....

☐ Urgent ☐ Semi –urgent ☐ Routine

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MR/352910

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