Referral for Iron Infusion Clinic

Charlestown Family Medical Services
42a Smith Street
Charlestown NSW 2290
Ph: 4942 2533
Fax: 4943 4266
ABN: 84 060 873252

Date:……

Dear Dr Elaine Stafford

Patient Details:

Name:…….

Address:…….

……

Contact Number:……

I am referring my patient to your clinic for a 1g infusion for Ferrinject.

Fe studies (no more than 4 weeks old):

Hgb (no more than 4 weeks old):

Patient is more than 14 years of age.
If patient is female and of child bearing age, I have ascertained that she is not currently pregnant.
I understand I am managing the iron deficiency and the clinic will simply provide an iron infusion.
I have provided the patient with a Ferrinject script,(500mg x 2), which they will fill and bring with them on the day of the infusion.
I have provided the patient with a Ferrinject CMI.
I have provided them with a pathology form, for a Hgb and Fe studies for 4 weeks post infusion date.

Past History:

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Current Medications:

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Allergies:

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Thank you for your care and assistance. I look forward to hearing the outcome of their attendance.

Yours sincerely

Doctor Name:……..

Provider Number:……

Address:……...

…….

Contact Phone:…….

Referring Doctor's Stamp: