glen iris medical group
Inc. Glen Iris Travel Health

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INTRAVENOUS INFUSION REFERRAL FORM

PATIENT DETAILS				
Name:		Date of Birth:		
Address:		Medicare No. & IRN:		
		Phone:		
		Email:		
		Emergency Contact	Name:	
			Phone:	

RELEVANT MEDICAL HISTORY

MEDICATIONS	
Allergies?	

INFUSION REQUESTED

☐ Zoledronic acid

Please provide script to patient for:

☐ Zoledronic acid 5mg/100mL injection

or ☐ Zoledronic acid 4mg/5mL injection

Indication:	
Please attach blood test results from within last 3 months: kidney function, calcium, vitamin D	

☐ Iron

Please provide script to patient for:

☐ Ferinject ® (ferric carboxymaltose)

or ☐ Monofer ® (ferric derisomaltose)

Indication:		
Dose:		mg
Please attach blood test results from within last 3 months: full blood count, iron studies, CRP		

FLUID RESTRICTION?

My patient is on a fluid restriction: ☐ YES ☐ NO

If YES, what is the daily fluid volume allowed? _____ mL over 24 hours

REFERRING DOCTOR

☐ I confirm that I am responsible for the assessment and follow-up of the underlying condition for which this infusion has been provided

Name:			
Provider Number:			
Address:			
Phone:			
Email/Fax/HealthLink EDI:			
Signature:		Date:	