glen iris medical group
glen iris travel health

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INTRAVENOUS INFUSION REFERRAL FORM

(TO BE COMPLETED BY DOCTOR ONLY)

PATIENT DETAILS

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

RELEVANT MEDICAL HISTORY

Pregnant?	☐ YES ☐ NO	***If Yes, Gestation?***	

MEDICATIONS

Allergies?		☐ **LATEX ALLERGY?**

INFUSION REQUESTED

☐ Zoledronic acid

Referring Dr please provide script to patient for:

☐ Zoledronic acid 5mg/100mL injection

or ☐ Zoledronic acid 4mg/5mL injection

Indication:	
Please attach health summary, DEXA scan & blood test results from within last 3 months (kidney function, calcium, vitamin D)	

☐ Iron

Referring Dr please provide script to patient for:

☐ Ferinject ® (ferric carboxymaltose)

or ☐ Monofer ® (ferric derisomaltose)

Indication:		
Dose:		mg
Please attach health summary & 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:	