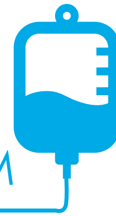
ivklinik



IV INFUSION REFERRAL FORM

Appointment availability Tue – Sat

Please call ivklinik on **02 9133 8500**

or alternatively email us on hello@ivklinik.com.au

Name: ______________________ DOB: ____________

Address: ______________________________________

Mobile: ______________ Email: __________________

CLINICAL INFORMATION

Diagnosis: ______________ HB: ______________

Allergies: ______________ CREAT: ______________

Weight: ______________ EGFR: ______________

Height: ______________ Ferritin: ______________

Please tick any that may apply

☐ Pregnant ☐ Fluid Restriction ☐ Heart Failure ☐ Renal Failure

IRON ORDER

TYPE OF IRON *given in divided doses: Max 1g per infusion*

DOSE CALCULATOR

☐ **Ferinject 0.5g** (x1 vial)
☐ **Ferinject 1g** (X2 vials)
☐ **Ferinject 1.5g** (x3 vials)
☐ **Ferinject 2g** (x4 vials)

	Weight <70kg	Weight >70kg
Hb<100g/L	1.5g	2g
Hb>100g/L	1g	1.5g

Please ensure patient has been issued a valid script, our clinic does not keep iron on site, patient will require to have script filed prior to appointment

OR

☐ **Monofer 0.5g** (x1 vial)
☐ **Monofer 1g** (X2 vials)
☐ **Monofer 1.5g** (x3 vials)
☐ **Monofer 2g** (x4 vials)

	Weight <70kg	Weight >70kg
Hb<100g/L	1.5g	2g
Hb>100g/L	1g	1.5g

REFERRING DOCTOR

Name: ______________________ Provider no: ____________

Address: ______________________________________

Phone: ______________ Email: __________________

Signature: ______________________ Date: ____________