Monaro Consulting Suites
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heathlink edi: Rutledge

Date:

IRON INFUSION REFERRAL

Name

DOB

Mobile Ph **Home Ph**

Address

Medicare

Please provide the patient with a valid prescription for requested dose

IRON ORDER (Pregnant women must be beyond 16 weeks gestation)

☐ Ferrinject 500mg (1 vial)
☐ Ferrinject 1g (2 vials)

Please attach Fe Studies & FBC less than 4 weeks old

Doctors Name
Address
Phone
Fax

Doctors Signature:_____

PATIENT INFORMATION

My doctor and I have discussed my condition(s) and the ways they may be treated, including the option of an Iron Infusion. My doctor has informed me, and I understand:

- An Iron infusion has been propsed as a treatment for me
- This procedure carries some risks, and complications may occur, and
- Additional treaments may be needed to acheive the desire results

I understand that I may withdraw my consent, I request and consent to receive an Iron Infusion

Patients Signature:_____ Date:

- Payment is required on the day of treatment. We accept credit cards (Visa, Mastercard, EFTPOS)
- There is no provision for the care of children, you are unable supervise children while receiving an infusion
- Please wear loose fitting clothes to allow your sleeve to be pushed well past your elbow

Please ensure you have eaten and are hydrated before your appointment