# **Referral form for iron infusion for iron deficiency anaemia**

Referring clinician details

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient details

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel No : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicare Card No:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Concession/Health care card No:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interpreter required: Y/N

Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Checklist prior to referring (please tick) – The following information must be provided or else the referral may be returned:**

* Referring GP to sign affirming that s/he is investigating underlying cause of anaemia

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Aged over 16 years
* Not in first trimester of pregnancy
* Iron deficiency anaemia confirmed (must have low haemoglobin AND low ferritin – low ferritin alone is not sufficient) (attach copy of result)
* Reason why oral iron replacement unsuitable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No allergy to iron products

Please fax the referral to Utopia and our staff will contact the patient for an appointment.