Rere Ora Infusion Clinic: Referral for Therapy Administration Only

Note: This referral is for the administration of therapy only. It does not constitute a referral for investigation or other management.

Patient Details:

- **Name: _____ DOB: _____ Phone: _____**
- **NHI #: _____**

Clinical Information

- **Allergies: _____ Weight: _____ Hb: _____**
- **Ferritin: _____ TSAT: _____ CRP: _____**

Medical History (Check relevant conditions)

☐ Fluid Restriction ☐ Heart Failure ☐ Renal Failure

Previous Iron Infusion

- **Had an iron infusion before?** □ Yes / □ No
- **If Yes, adverse reaction?** □ Yes / □ No

Iron Order (Check one)

☐ Ferinject 500mg (1 vial) ☐ Ferinject 1000mg (2 vials)

Do not administer more than 1000mg of iron per week.

Referring Practitioner Name: _____ MCNZ Reg. #: _____

Address: _____

Signature: _____ Date: _____

Administrator/Registered Nurse: Sonia Halbert **Reg. #:** 186695

Signature: _____ Date: _____

Time Given: _____
