Eastern Health

HOSPITAL IN THE HOME
IRON INFUSION REFERRAL

UR number:

Surname:

Given name:

Date of birth: DD/MM/YYYY Sex: M / F

(Affix hospital ID label if available)

FEH317148

All sections of this referral must be completed and emailed to HITH@easternhealth.org.au

Referral date: DD/MM/YYYY 3 Point ID check: ☐ No ☐ Yes

Referring facility: ☐ EH inpatient ☐ EH outpatient ☐ Private Specialist clinic ☐ General Practice

Referring Doctor: Designation:

Referrer's contact no.: Referrer's email:

Referring unit: Approving Consultant (If Reg / HMO):

Principal diagnosis(es) or problem(s)

Allergies ☐ No ☐ Yes If yes, specify:

Please fill out / tick all that apply (Referral will be returned if adequate information not provided):

☐ Hb: MCV: (Please provide copy of results)

☐ Iron studies (Please provide copy of results)

Does the patient have any of the following:

☐ Ongoing active bleeding. Please specify:

☐ Awaiting surgery. Date of planned surgery: DD/MM/YYYY

☐ Starting dialysis or EPO. Date of planned commencement: DD/MM/YYYY

☐ HFrEF with signs of decompensation or NYHA class II-IV

☐ Active malignancy

☐ Malabsorption. Please specify:

Has the patient trialled oral iron therapy (100mg elemental iron daily for 60 - 90 days)?

☐ No ☐ Yes If yes, please specify:

Does the patient reside in a RACF / SRS?

☐ No ☐ Yes

If yes, please fill out / tick all that apply:

Is the patient: ☐ Active ☐ Minimally mobile ☐ Bed-bound

Does the patient have capacity to consent to iron infusion: ☐ No ☐ Yes

Who is the surrogate decision maker: Contact no.:

History of BOC / aggression? ☐ No ☐ Yes

Relevant medical history:

Special considerations:

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