INFUSION REFERRAL FORM

SPRING EMERGENCY CENTRE
RAPID EXPERT EMERGENCY CARE

Patient Information			
Name:			
DOB:		Phone/Mobile:	
Clinical Information			
Indication for therapy:			
Allergies:			
Weight:			
Fluid Restriction (if applicable):			

The prescriber assumes all responsibility for the completion and review of relevant screening tests prior to referral

PLEASE ISSUE A VALID SCRIPT TO PATIENT FOR ALL REQUESTED DRUGS

Pre Medication Order		
☐ Hydrocortisone Dose: _____ mg/VI	☐ P O Paracetamol 1g	☐ P O Loratadine 10mg
☐ Methylprednisolone Dose: _____ mg/VI	☐ Other: _____	
Iron/Bisphosphonate Order		
☐ Ferinject 500mg {single session)	☐ Ferinject 2g {over 2 sessions)	☐ Monofer 1.5g {over 2 sessions)
☐ Ferinject 1g {single session)	☐ Monofer 500mg {single session)	☐ Monofer 2g {over 2 sessions)
☐ Ferinject 1.5g {over 2 sessions)	☐ Monofer 1g {single session)	☐ Zoledronic acid 5mg (single session)
☐ Other Infusion:		
☐ Methylprednisolone Dose: _____ mg/VI		
Biologic Order		
☐ Infliximab: _____ mg ☐ Induction ☐ Maintenance or biosimilar	☐ Tocilizumab: _____ mg IVI every 4 weeks	
☐ Ocrelizumab: _____ mg ☐ Induction ☐ Maintenance	☐ Ustekinumab: _____ mg ☐ IV ☐ SC	
☐ Anifrolumab: _____ mg ☐ Induction ☐ Maintenance	☐ Eptinezumab 100mg (3 monthly ongoing)	
☐ Vendolizumab: _____ mg ☐ Induction ☐ Maintenance	☐ Eptinezumab 300mg (3 monthly ongoing)	
☐ Natalizumab: _____ mg/VI every 4 weeks		
☐ Other biologic/biosimilar: Drug _____ Dose: _____mg Frequency: _____		
Antibiotic/Other Order		
☐ Cephazolin 1g	☐ Cephazolin 2g	☐ Ceftriaxone 1g	☐ Ampicillin 1g
☐ Ampicillin 2g	☐ Gentamicin Dose: _____	☐ Maxolon 10mg	☐ Stemetil 12.5mg
☐ Vitamin C	☐ Ondansetron ☐4mg ☐8mg	☐ Other:	

Referring Doctor

Name:		Provider No:	
Address:			
Signature:		Date:	

By signing, I confirm the following: I have explained the purpose, risks, and side effects of this treatment. The patient understands they may withdraw consent at any time. The patient has no known contraindications, and I have provided a valid prescription, along with relevant blood results (less than 4 weeks old) and supporting clinical documentation.

Send referrals to reception@springmedicalgroup.com.au

9/131 Henry Parry Drive, Gosford NSW 2250
Phone: (02) 4380 8200 Website: www.springemergency.com.au