AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Iron Infusion Referral (Pre Operative Services)

MUST ATTACH PATIENT LABEL HERE

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

Please ensure you attach the correct visit patient label

INTERNAL REFERRAL ONLY *(Please scan form and send to **Ironinfusion@adhb.govt.nz**)*

DATE & RESULTS

Hb: _____

Ferritin: _____

CRP: _____

Anaemia cause and investigation (one must be ticked)

☐ The iron deficiency cause is known and requires no further investigation

☐ The iron deficiency cause is unknown and the referrer is investigating further

☐ The iron deficiency cause is unknown and the referrer has contacted the GP to investigate further

Planned procedure: _____

Date of Surgery (if known): _____

Other relevant details re indication (including nature & urgency of planned surgery):

_____

_____

_____

Previous reactions to iron? ☐ Yes ☐ No
(One must be ticked)

Referrer's Details

Name: _____ Mobile / Pager: _____

Signature: _____ Date: _____

Decision

☐ Iron infusion only ☐ Iron infusion & further investigation ☐ No infusion to be given

Date infusion booked: _____

Clinician's Comments:

_____

_____

_____

Clinician's Details

Name: _____ Mobile / Pager: _____

Signature: _____ Date: _____

IRON INFUSION REFERRAL PRE OPERATIVE SERVICES

SINGLE SIDED FORM – Reverse not scanned
DO NOT DOCUMENT CLINICAL NOTES ON BACK

01/21

CR4034