Sonic Nurse Connect

FERINJECT® INFUSION SERVICE - Patient Referral for Treatment

(ferric carboxymaltose)

OFFICE USE ONLY:	Patient ID: ☐☐☐☐☐☐	Control Number: ☐☐☐☐☐☐

INSTRUCTIONS

I. Prior to referring a patient to Sonic Nurse Connect for a community FERINJECT infusion, please consult the FERINJECT Product Information for contraindications and precautions

II. To refer a patient, please complete both sides of this form and forward to SONIC NURSE CONNECT

III. SONIC NURSE CONNECT reserve the right to assess the eligibility of the patient for a community FERINJECT infusion

IV. Please ensure the patient is aware of the out of pocket cost for the infusion (contact SONIC NURSE CONNECT for current fee)

PRESCRIBING DOCTOR details

First name:	Last name:
Clinic Address:	
State:	Postcode:
Phone: (0)	Fax: (0)
Email:	Provider Number:

PATIENT details

First name:	Last name:
Gender: M ☐ F ☐	Date of birth: DD / MM / YYYY
Mailing Address:	
State:	Postcode:
Phone: (0)	Mobile:
Email:	
Patient emergency contact name:	Phone: (0)
Relationship to patient:	

INDICATION

☐ Intolerance to oral iron

☐ Non-compliance with oral iron

☐ Lack of efficacy with therapeutic doses of oral iron

☐ Ongoing iron/blood loss exceeding absorption

☐ Intestinal malabsorption of iron

☐ Absolute or functional iron deficiency in patients with cardiac failure

☐ Severe iron deficiency needing rapid iron repletion to prevent transfusion

☐ Short time to non-deferrable surgery associated with substantial blood loss

PATIENT history (information required for referral to be processed)

☐ Medical History & Medications Summary attached

☐ Current Pathology Report for Hb and Ferritin attached

Sonic Nurse Connect

FERINJECT® INFUSION SERVICE – Medication Order

(ferric carboxymaltose)

OFFICE USE ONLY:	Patient ID: ☐☐☐☐☐☐	Control Number: ☐☐☐☐☐☐

PATIENT details

First name:	Last name:
Gender: M ☐ F ☐	Date of birth: DD / MM / YYYY
Allergies:	Weight:

INFUSION LOCATION

☐ My Clinic/Medical Centre ☐ Please book a consultation for my patient with me immediately prior to the FERINJECT infusion (**Optional**)

☐ SONIC NURSE CONNECT Community Infusion Centre

MEDICATION ORDER For single infusion of a maximum dose of 1000mg

(to be completed by prescribing doctor)

Medication:	**FERINJECT® (ferric carboxymaltose)**	**RECORD OF ADMINSTRATION (to be completed by Nurse)**		
		Date	**Time**	**Nurse signature**
Route:	IV			
Dose (mg):				
Dilution: (mL 0.9% NaCl)				**Nurse Name:**

SNC USE ONLY

If total dose > 1000mg please order the second Infusion to be given ≥ 1 week following first dose

(Strike through if not required)

Medication:	**FERINJECT® (ferric carboxymaltose)**	**RECORD OF ADMINSTRATION (to be completed by Nurse)**		
		Date	**Time**	**Nurse signature**
Route:	IV			
Dose (mg):				
Dilution: (mL 0.9% NaCl)				**Nurse Name:**

SNC USE ONLY

Special Instructions:		
Prescribing Dr name:	**Prescribing Dr signature:**	**Date of order:**

PLEASE SEND COMPLETED FORM TO SONIC NURSE CONNECT

EMAIL: referrals@snc.com.au FAX: 1800 316 766 PHONE: **1800 INFUSE (1800 463 873)**