the Infusion CLINIC

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# Specialist Referral

Dr Adrian Sartoretto and Associates

PATIENT NAME: ..... DOB: .....

ADDRESS: .....

PHONE: ..... ☐ Male ☐ Female

## CLINICAL INFORMATION

ALLERGIES: .....

INDICATION FOR REFERRED THERAPY: ..... WEIGHT: ..... CREAT: ..... eGFR: .....

****PLEASE ISSUE A VALID SCRIPT TO PATIENT FOR ALL REQUESTED DRUGS****

*Progress blood tests can be collected at each infusion. Please provide pathology request forms and indicate the approximate date of collection.*

## PRE-MEDICATION

☐ **Methylprednisolone** Dose: .....

**Hydrocortisone** ☐ 50mg IVI ☐ 100mg IVI ☐ **Loratidine** 10mg po ☐ **Other:** .....

## BLOOD PRODUCTS

☐ **Concentrated Albumin 20%** ..... units

☐ **IVIg: Dose** ..... **Frequency** ..... **Duration** .....

**IVIg Supply:** ☐ **Under National Criteria** ☐ **Private** (Specify Product) .....

## BIOLOGIC AGENTS

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

**Infliximab:** ☐ Remicade® ☐ Inflectra® ☐ Renflexis®

**Dose:** ..... ☐ Round dose up to nearest whole vial

☐ **Tocilizumab Dose:** ..... ☐ **Vedolizumab Dose:** .....

☐ **Natalizumab Dose:** ..... ☐ **Ocrelizumab Dose:** .....

**Treatment phase:** ☐ Induction ☐ Maintenance

**Ustekinumab Dose:** ☐ IV ☐ SC For IBD indications only. Single dose only

| Body weight of patient at the time of dosing | Dose | Number of 130mg/26mL (5mg/mL) Stelara® vials |
|---|---|---|
| ☐ 55kg or less | 260mg | 2 |
| ☐ 55kg to 85kg | 390mg | 3 |
| ☐ more than 85kg | 520mg | 4 |

## INTRALIPID®

☐ **100mL of Intralipid® 20% in 500mL NS infused as per protocol**

**Date of commencement:** ..... / ..... / ..... **Frequency:** ..... **Duration:** .....

Other protocol Volume: ..... of Intralipid® 20% in ..... NS 0.9% **Frequency:** ..... **Duration:** .....

☐ **1st Treatment** Date: ..... ☐ **2nd Treatment** Date: ..... ☐ **3rd Treatment** Date: .....

## OTHER ORDER / NOTES

.....

.....

## CONSENT

My medical practitioner and I have discussed my present condition(s) and the various ways in which it may be treated, including the above proposed procedure and/or treatment. The doctor has informed me, and I understand:

- The procedure/treatment proposed;
- The procedure/treatment carries some risks, and complications may occur; and
- Additional treatments may be needed to achieve the desired results.

I understand that I may withdraw my consent. **I request and consent** to the procedure/treatment described above for me.

**Patient's signature:** ..... **Date:** .....

## REFERRING SPECIALIST

*Please provide a new referral with each new prescription*

NAME: .....

ADDRESS: .....

SIGNATURE: ..... PROVIDER No: ..... DATE: .....

*Please note this referral is for the administration of parenteral therapy only, this does not constitute a referral for investigation or other management.*