the Infusion CLINIC
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Specialist Referral

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

PATIENT

NAME:..... DOB:..... PHONE:.....

CLINICAL INFORMATION

Indication for referred therapy: .....

ALLERGIES: ..... **WEIGHT:** ..... **CREAT:** ..... **eGFR:** .....

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

PRE-MEDICATION

☐ **Hydrocortisone:** ☐ 50mg IVI ☐ 100mg IVI ☐ **Methylprednisolone:** Dose: ..... mg IVI ☐ **Loratidine:** 10mg PO .....

INTRAVENOUS BIOLOGIC AGENTS

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

☐ **Infliximab:** ☐ Induction ☐ Maintenance
☐ Remicade® ☐ Inflectra® ☐ Renflexis® Dose: ..... mg IVI ☐ Round dose up to nearest whole vial

☐ **Tocilizumab** Dose: ..... mg IVI every 4 weeks

☐ **Vedolizumab** Dose: ..... mg ☐ Induction ☐ Maintenance

☐ **Natalizumab** Dose: ..... mg IVI every 4 weeks

☐ **Ocrelizumab** Dose: ..... mg ☐ Induction ☐ Maintenance

☐ **Ustekinumab:**

☐ IV Dose: ..... mg

☐ SC Dose: ..... mg *(For IBD indications only. Single dose only)*

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

INTRAVENOUS INTRALIPID®

☐ 100mL of Intralipid® 20% in 500mL Normal Saline 0.9% infused as per *The Infusion Clinic* protocol

☐ **Alternative protocol:**
Volume: .....mL of Intralipid® 20% in volume .....mL Normal Saline 0.9%
Duration of infusion: ..... hours

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

INTRAVENOUS BLOOD PRODUCTS

☐ **Concentrated Albumin 20%** ..... units ☐ **IVIg:** Dose: ..... Frequency:..... Duration: .....

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

Specify: Product: ..... Dose: ..... Frequency: .....

OTHER ORDER / NOTES

CONSENT *(consent to be completed with referring Doctor)*

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 consesnt. **I request and consent** to the procedure/treatment described above for me.

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

REFERRING SPECIALIST: (Drs Signature essential for valid order) *Please provide a new referral with each new prescription.*

NAME: ..... **PROVIDER No.** .....

ADDRESS: .....

DOCTOR'S SIGNATURE: ..... **DATE:** .....

ABN: 52 168 930 818