# Subspecialist Referral

the Infusion CLINIC
Dr Adrian Sartoretto and Associates

☐ Level 1 | 66 High Street
**RANDWICK NSW 2031**
p: **1300 122 300**
f: 1300 122 399
e: reception@infusionclinic.com.au

☐ Level 3 | Suite 305 | 161 Bigge St
**LIVERPOOL NSW 2170**
p:**1300 122 600**
f: 1300 122 699
e: liverpool@infusionclinic.com.au

☐ Level 1 | 517 St Kilda Road
**MELBOURNE VIC 3004**
p:**1300 122 400**
f: 1300 122 499
e: melbourne@infusionclinic.com.au

www.infusionclinic.com.au

**Please note this referral is for ADMINISTRATION OF THERAPY ONLY, this DOES NOT constitute a referral for investigation or other management**

## PATIENT

**Name:** ..... **DOB :** ..... **Phone:** .....

**Medicare No.:** ..... ***Ref No.:*** ..... **Weight:** .....kg

**Allergies:** .....

**Indication for referred therapy:** .....

**Pregnant:** ☐ No ☐ Yes: (*Gestation in weeks* .....) ☐ **Fluid Restriction /Professional Athlete** ☐ **Heart Failure** ☐ **Renal Failure**

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

The prescriber assumes all responsibility for gaining INFORMED CONSENT from the patient, the completion and review of relevant screening tests

## PREMEDICATION

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

## BIOLOGIC & BIOSIMILAR AGENTS **I confirm completion and review of relevant screening tests prior to referral**

### GASTROENTEROLOGY

☐ **INFLIXIMAB:** ☐ **Ixifi®** ☐ **Remicade®** ☐ *Induction* ☐ *Maintenance* ☐ **Remsima®** Induction doses x 2 ONLY

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

**Frequency:** ☐ 0, 2, 6 then every **6 weeks** ☐ 0, 2, 6 then every **8 weeks** 2 weeks apart. *Then Subcutanous*

☐ **Stelara® (*Ustekinumab*): Dose:** .....mg **IVI**

**Frequency:** ☐ 0, 4 then every **12 weeks**

| Induction dosing of IV STELARA by weight | | |
|---|---|---|
| Body weight at time of dosing | Dose | Number of Stelara Vials *130 mg/26 mL (5 mg/mL)* |
| 55 kg or less | 260mg | 2 vials |
| 55 kg to 85kg | 390mg | 3 vials |
| More than 85kg | 520mg | 4 vials |

☐ **Stelara® (Ustekinumab): 90mg Subcutaneous** *(for IBD induction only.* ***Single dose only)***

☐ **Entyvio® (Vedolizumab ): 300mg IVI** At 0, 2 and 6 weeks and t**hen every 8 weeks** ☐ *Induction* ☐ *Maintenance*

### RHEUMATOLOGY

☐ **Actemra® (*Tocilizumab*):** 8 mg/kg **IVI,** every **4 weeks** *(DO NOT EXCEED 800mg for patients >100kg)*

☐ **Saphnelo® (*Anifrolumab*):** 300mg **IVI,** every **4 weeks**

## BISPHOSPHONATES

☐ **Aclasta® (*Zoledronic acid*)** 5 mg **IVI, once**

☐ **Pamisol® (*Pamidronate*): Dose IVI:** ..... **Frequency:** .....

## INTRAVENOUS INTRALIPID®

☐ **100mL of Intralipid® 20%**

***Diluent:*** 500mL Normal Saline 0.9%

***Duration of infusion:*** Over 2 hours as per *The Infusion Clinic* protocol

☐ **Alternative protocol:**

**Volume:** .....mL of **Intralipid® 20%** in

***Diluent:*** .....mL of 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** ☐ **Under National Blood Authority Criteria** ☐ **Organised with Private supplier:** .....

***Product:*** ..... ***Dose:*** ..... ***Frequency:*** ..... ***Duration (months):*** .....

## OTHER ORDER / NOTES **Please specify:** Drug, dose, route, frequency and duration. ***Contact us to confirm this medication is offered***

## REFERRING DOCTOR **(NEW REFERRAL IS REQUIRED WTH EACH NEW PRESCRIPTION. Drs signature essential for valid order.)**

**By signing below,** I confirm that I am the prescribing practitioner and confirm this prescription is clinically appropriate and without contraindication. Clinical responsibility rests with the prescriber, and The Infusion Clinic administers medication in accordance with this prescription. I confirm I have obtained the patient's informed consent, including discussion of risks, benefits, and alternatives, and that consent may be withdrawn at any time.

**Subspecialist's Name:** ..... **Provider no.:** .....

**Practice Address:** ..... **Phone number:** .....

☐ Please send correspondence **via *HealthLink***

**Subspecialist's Signature:** ..... **Date:** ..... ☐ Please send ***referral pads***

*****Referrer MUST have completed referrer registration at www.infusionclinic.com.au/registration/**



ABN: 52 168 930 818

the Infusion CLINIC

## RANDWICK

**Address:**
Level 1 | Wales Medical Centre
66 High Street | RANDWICK

**Parking:**
Royal Randwick Shopping Centre

**Light Rail Stop:**
Randwick

**Phone: 1300 122 300**

**Email:**
reception@infusionclinic.com.au

**Appointments:**
Monday to Saturday

## LIVERPOOL

**Address:**
Level 3 | Suite 305
161 Bigge Street | LIVERPOOL

**Parking:**
Warren Serviceway Parking Station

**Train:**
Liverpool Railway Station

**Phone: 1300 122 600**

**Email:**
liverpool@infusionclinic.com.au

**Appointments:**
Monday to Friday

## MELBOURNE

**Address:**
Level 1 | Suite 2
517 St Kilda Road | MELBOURNE
*(300m from The Alfred Hospital)*

**Tram Stops:**
Commercial Road / St Kilda Road
Alfred Hospital

**Phone: 1300 122 400**

**Email:**
melbourne@infusionclinic.com.au

**Appointments:**
Monday to Friday

## ESSENTIAL PATIENT INFORMATION

- **Please note there is no facility provided for the care of children, and for safety reasons children cannot accompany you into the infusion room**
- **Payment is required on the day (Visa, Mastercard, EFTPOS or cash)**
- **Complimentary Wi-Fi is available**
- **Bring a jacket or a scarf** in case you get cold during the infusion
- For **patient privacy,** we ask that any person accompanying you remains in the waiting room
- **Wear loose clothing** so your sleeve can be rolled up above the elbow. Bring a jacket or scarf if you tend to feel cold.
- Eat normally and drink fluids beforehand. Unless your doctor has advised a fluid restriction, **drink 2 glasses of water in the 1–2 hours before your appointment to help with IV insertion**. If you have a heart or kidney condition, follow your doctor's advice regarding fluid intake

* **If you suffer from a heart or kidney condition, please ask your doctor the appropriate amount of hydration (fluid intake) you should have prior to the infusion** *

## INTRAVENOUS (IV) INFUSIONS

For the purpose of administering intravenous (IV) ˜uids, or medications, directly into the blood circ ulation, an IV cannula is inserted into a vein. At *The Infusion Clinic*, the IV cannula will be inserted by a trained nurse.

To ensure a safe infusion a large vein is selected, usually in the forearm. A tourniquet is applied, then a small plastic tube (cannula) is inserted into the vein via a needle. Once the cannula is inserted the needle is removed, leaving the soft cannula in the vein for administration of the medication and/or IV ˜ uid. The tourniquet is removed, and a dressing applied to secure the cannula.

Discomfort should be minimal and disappears soon after the needle is removed from the cannula.

The medication and/or IV ˜uid is then attached to the cannula for administration into the vein.

Following completion of the infusion the cannula is removed and pressure is applied to the site to stop any bleeding.

Bruising and irritation may occur at the cannula site for several days following the infusion. There is a small risk of infection with any medical procedure, **please monitor the IV site over the next 7 days for redness or pain**. Should either occur you should see your doctor for further assessment and any required treatment.



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