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: _____ Date: _____

Ferritin: _____ Date: _____

CRP: _____ Date: _____

Planned procedure: _____

Date of Surgery (if known): _____ Patient has known history of Anaemia: Yes ☐ No ☐

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

_____

_____

_____

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

CR4034