BAYNAV 1007 8/22

Te Whatu Ora
Health New Zealand
Hauora a Toi Bay of Plenty

REFERRAL - AMBULATORY INFUSION (NON-IRON INFUSIONS)

Patient Name: _____

Address: _____

DOB: _____ Age: _____

☐ Male ☐ Female NHI: _____

Date: _____

PATHWAY

Referred and triaged by: ☐ Specialist _____

or delegate ☐ Name/Title _____ on behalf of specialist: _____

Health Specialty / Department: _____

(Specialty which referral will be recorded under)

Suspicion of Cancer at time of referral ☐ Confirmed ☐ High ☐ Low or no suspicion

INDICATION

BACKGROUND *(Significant past history)*

ASSESSMENT

Weight _____ Kg **Height** _____ cm **BSA** (Du Bois)_____ m²

MEDICATION

Name: _____ ☐ **Pre-meds** ☐ **Fluids**

Frequency *(One-off or regular)*: _____

Dosage: _____ **Route:** _____

RESPONSIBLE CLINICIAN

Clinician: _____ Pager No: _____ Phone No: _____

CHECKLIST *(To be completed by Referrer / Triaging Clinician)*

Referral Completed and scanned	☐ Yes
Medication chart completed and scanned	☐ Yes
Does patient require IV GUIDED US	☐ Yes *Please complete and scan Radiology Referral* ☐ N/A
Pre-biologic screening complete	☐ Yes
Appropriate medication authorisations obtained	☐ Yes

☐ **Grade 1** *(< 2 weeks)* ☐ **Grade 2** *(2 - 6 weeks)* ☐ **Grade 3** *(> 6 weeks)* ☐ **Not before date:** _____

Signature *(Referrer / Triaging Clinician)* _____

Pager / Phone No: _____

CLICK TO PRINT

PRINT, SCAN AND EMAIL WITH MEDICATION CHART TO:
infusion.scheduler@bopdhb.govt.nz