

Please circle if you would like to receive a **referral receipt** via: Fax | Email | Phone | Not required

Patient information	
Name:	Next of kin name:
DOB:	Relationship:
Address:	Next of kin phone:
Is this the patient's home address? ☐ Home ☐ Other	Patient Medicare number:
Phone:	Email:
Referrer information	
Name:	Phone:
Position:	Email:
Hospital/facility:	Have you referred to Vitalis before? ☐ Yes ☐ No
Referral details	
Iron required:	Iron dose:
Has the patient had an iron infusion in the past? ☐ Yes ☐ No	Who will be supplying the iron?
When did they have their iron infusion?	☐ Vitalis to supply for Medibank/ahm members (no extra cost)
Did they have any adverse reactions? ☐ Yes ☐ No	☐ Vitalis to supply for other patients (extra cost involved)
Provide details:	☐ Patient/facility will supply
Any behavioural alerts Vitalis should be aware of? ☐ Yes ☐ No	
Does patient have difficulties with cannulation*? ☐ Yes ☐ No	Provide details:
Provide details:	Can patient provide own consent? ☐ Yes ☐ No
	Decision-maker details:
Payment details	
Who is paying for the iron infusion?	
☐ Private Health Insurance Fund	☐ Individual/private
Which fund is the patient a member of?	Quote will be sent for review. Payment in full required before visit.
☐ Medibank	
☐ ahm	
☐ Other (please name):	
Medibank/ahm member no. (to check eligibility):	
Attachment checklist	
☐ Doctor referral letter (if this form is being completed by a nurse)	Health summary
	Recent blood tests
Authorisation	
Name:	Signature:
Date:	Role/title:

*Vitalis nurses can only attempt cannulation twice.