**Ferinject Referral**

**Date**

**Patients Name**   **Date of Birth**

**NHI**

**Address**

**Phone (**Home) (Mobile)

**Reason for Referral**

**Essential;**

**Pregnancy / Antenatal / Other**

**Serum Haemaglobin level**  **Serum Ferritin level**

**CRP (if indicated)** **Serum Phosphate Level**

**Is Patient Special Authority** Y / N

**POAC Subsidy Voucher**

**Special Authority Number**

**Current Medications**

**Allergies**

**Referring Doctor**

**Practice**

**Signature**  **Date**