RENAL Referral Form – Infusion Suite

Patient Details: (Patient Sticker)	Date of Referral:
	Consultant:
	Referring Clinician: (If different to consultant)
Main Diagnosis:	

PRE-SCREEN COMPLETED	N/A	YES	NO

TREATMENT REQUIRED:		TIME SCALE:		TREATMENT PLAN:
RITUXIMAB		Within 72 Hrs		(i.e. Immunoglobulin / Cyclophosphamide pattern of treatment)
INFLIXIMAB		1-2 Weeks		
IRON		3-4 Weeks		
IMMUNOGLOBULINS		5-8 Weeks		
CYCLOPHOSPHAMIDE				
OTHER TREATMENT: (Please give details)				

Further Relevant Information: (Including any mobility issues)

Infusion Suite Use:	
Date Received:	**Date Booked:**
Appointment Dates:	