

## NON-CHEMOTHERAPY INFUSION REFERRAL

**To:** PENINSULA ONCOLOGY CENTRE    **Date:** \_\_\_\_\_

Can you please supply the following information regarding your patient. We can contact the patient directly to make an appointment to attend for treatment.

Drug infusion orders can be emailed to: [info@poc.com.au](mailto:info@poc.com.au) or Faxed to **(03) 9771 8991**.

**Preferred Dr:** \_\_\_\_\_    **Patient Name:** \_\_\_\_\_

**D.O.B:** \_\_\_\_\_    **Phone Number:** \_\_\_\_\_

**Health Insurance Fund:** \_\_\_\_\_

1.     BLOOD TRANSFUSION
2.     IRON INFUSION
3.     IMMUNOGLOBULINS
4.     INFLIXIMAB
5.     TYSABRI
6.     ABATACEPT
7.     ACTEMRA
8.     PAIN MANAGEMENT
9.     OTHER

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