Adelaide Plastic Surgery

Infusaport booking referral Fax: 8213 1811

Surgeon: Dr Beverley Fosh

Oncologist: .....

GP: .....

Patient Information

Surname: .....

Given name: .....

DOB: ..... Gender: F M

Phone number: .....

Reason for Infusaport

Please specify *eg breast cancer*: .....

When is chemotherapy due to commence? .....

Gripper needle required Yes No

Patient Health Assessment

Is there a possibility the patient is pregnant Yes No

Medical Condition Check

Diabetes	Yes	No
Cardiac stents	Yes	No
Severe Heart Disease	Yes	No
Pacemaker	Yes	No

Unable to consent

Mental Illness	Yes	No
Dementia	Yes	No
Non English Speaking	Yes	No

Has the patient had chest wall radiotherapy Yes No

Medications

Does patient take blood thinning medication Yes No

Ie Aspirin(Cartia, Aspro,Disprin,Astrix),Warfarin(MarevanmCoumadin), Clopidogel(Iscover,Plavix) or arthritis drugs

Does patient take any other prescription or non prescription

(Nurofen, voltarin or alternative medications) Yes No

If Yes, name .....

Special instructions

Cease Warfarin 4 days prior

Need Bloods- CBE, COAGS, U&E

Cease Clopidogre/Aspirin 10 days prior

Referring doctor to order 1-2 days prior

Please accept this as a referral for an infusaport for STAMP Below

Dr .....

Signed .....