

# INTRALIPID ORDER FORM

## Fertility Specialist Referral

Infusions are performed at Dermaluxe Injectables – 138 Shannon Avenue Geelong West, Vic 3218



Patient: \_\_\_\_\_

DOB: \_\_\_\_\_

Phone: \_\_\_\_\_

**Intralipid® 20%**

Volume: 200mls

Duration of infusion: Over 2 hours

1st Treatment Date: \_\_\_\_\_

2nd Treatment Date: \_\_\_\_\_

3rd Treatment Date: \_\_\_\_\_

### Alternative Order:

Intralipid \_\_\_\_\_ %

Volume: \_\_\_\_\_

Duration of Infusion: \_\_\_\_\_

### REFERRING DOCTOR (Drs Signature essential for valid order)

NAME: \_\_\_\_\_ PROVIDER No. \_\_\_\_\_

ADDRESS: \_\_\_\_\_

**DOCTOR'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

\*\* If you would like to create a standing order for future patients, please contact the clinic via email to have one in place \*\*

Please complete and return this form to:  
[admin@themidwiferycentre.com.au](mailto:admin@themidwiferycentre.com.au)  
Patients can book online once referral is complete.