For new referrals, please include recent labs and last two office visit notes.

Fax completed form to (724) 240-1586

Phone (724) 510-3702

1. PATIENT INFORMATION

Name:	DOB:
Phone:	Other Phone:
Email:	
Social Security #:	Allergies:
Gender: M F	Weight: Lbs Kg

Patient Status: New to therapy Continuing therapy Next due date *(if applicable)*:

2. INSURANCE INFORMATION *(required)*

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:		NPI#:
License #:	TIN#:	DEA#:
Address:		
City:		State Zip
Office Contact:		Email:
Office phone:		Office fax:

4. DIAGNOSIS INFORMATION (ICD 10 Code *Required*)

Crohn's Disease (______________) Ulcerative Colitis (______________) Other: __________________

*Labs: TB, Baseline Liver Enzymes, and Bilirubin required

5. PRESCRIPTION INFORMATION (*requires new order every 12 months*)

Crohn's Disease

Administer 900mg IV over at least 90 minutes at weeks 0, 4, and 8

Ulcerative Colitis

Administer 300mg IV over at least 30 minutes at weeks 0, 4, and 8

Vital signs per HI Protocol

Anaphylaxis & hydration management per HI Protocol

PRE-MEDICATIONS N/A

Acetaminophen 500mg 650mg 1000mg

Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)

Diphenhydrimine (Benadryl) 25mg 50mg PO IV (requires driver)

Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV

Prednisone ___________ mg PO

Other ________________________________

POST-MEDICATIONS N/A

Acetaminophen 500mg 650mg 1000mg

Prednisone __________ mg PO

Other ________________________________

6. LABS

CBC w/Diff	Each Infusion	Other Frequency (*specify*): ______________________________
CRP	Each Infusion	Other Frequency (*specify*): ______________________________
CMP	Each Infusion	Other Frequency (*specify*): ______________________________
ESR	Each Infusion	Other Frequency (*specify*): ______________________________
Hepatic Panel	Each Infusion	Other Frequency (*specify*): ______________________________
Renal Panel	Each Infusion	Other Frequency (*specify*): ______________________________

Quantiferon TB Gold, annually, last completed *(date)*: ____

Other (*specify*):____

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE DATE