

Patient Status: ☐ NEW* ☐ CONTINUING

Next Due Date (if applicable) _____ Choose Location _____

*Include recent labs and last 2 office visit notes

Name _____ DOB _____

Phone _____ Other Phone _____

Email _____ SSN _____

Allergies _____ Weight _____ ☐ LBS ☐ Kg Gender ☐ M ☐ F

INSURANCE INFORMATION (Required)

Submit copies of the front and back of primary and/or secondary insurance cards with this referral

Physician Name _____ NPI# _____

License # _____ TIN# _____ DEA# _____

Address _____

City _____ State _____ Zip _____

Office Contact _____ Email _____

Phone _____ Fax _____

DIAGNOSIS INFORMATION:

☐ _____ ICD 10 Code _____

***Required Labs: CMP/CBC/TSH/T4 within last 3 months**

DOSING

☐ 200 mg IV every 3 weeks

☐ 400 mg IV every 6 weeks

☐ Other _____

☐ 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)

☐ Diphenhydramine (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 _____

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): _____

Provider Signature _____

Date _____

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

Fax Referrals to: Kentucky (888) 977-0914 | New York (315) 457-4305 | Ohio (888) 977-0914 | Pennsylvania (724) 240-1586