



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)

Ulcerative Colitis ()
Crohn's Disease ()
Other: _____

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

Frequency Induction: 300mg IV week 0, 2, 6, and then every 8 weeks
Maintenance: 300mg IV every 8 weeks / Other:
Pen Administration Loading Dose: 300mg IV Week 0, Week 2
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 _____

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