

**Location**

Camillus
Liverpool
New Hartford
Watertown

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

Fax completed form to (315) 457-4305

Phone (315) 457-3091

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)

ICD 10 Code ()

****CMP/CBC/TSH/T4 within last 3 months****

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

OPDIVO

Enter dose and frequency:

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