Location

Liverpool

New Hartford

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*)

Rheumatoid Arthritis (______________) Other: _______________

*TB within last year and ANNUALLY
*HBV prior to starting; 1x occurrence unless HBV carrier

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

Initial Maintenance

Initial Dose: Administer 2mg/kg IV over 30 minutes at week 0 and 4; then every 8 weeks thereafter

Maintenance Dose: Administer ______mg at ______mg/kg IV every ______ week(s)

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