



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)

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

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

Frequency	PRE-MEDICATIONS	N/A
Induction: 300mg IV week 0, 2, 6, and then every 8 weeks	Acetaminophen	500mg 650mg 1000mg
Maintenance: 300mg IV every 8 weeks / Other:	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
Pen Administration Loading Dose: 300mg IV Week 0, Week 2	Other	
Vital signs per HI protocol	POST-MEDICATIONS	N/A
Anaphylaxis & Hydration Management per HI protocol	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