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*)

Type 1 diabetes mellitus with unspecified complications (________)

Type 1 diabetes mellitus without complications (________)

Other ____________________

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

Infuse Tzield IV daily for 14 days according to the below dosing regimen:

- Day 1: 65 mcg/m^2
- Day 2: 125 mcg/m^2
- Day 3: 250 mcg/m^2
- Day 4: 500 mcg/m^2
- Day 5 through 14: 1,030 mcg/m^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)

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

Baseline CBC & LFTs (required)

Baseline hold parameters: Lymphcyte count <1,000/mcL, Hgb <10g/dL, Platelets <150,000/mcL, ANC <1,500/mcl, ALT/AST >2x ULN, or bilirubin >1.5x ULN

Repeat CBC & LFTs every ____ day(s)

Notify physician for abnormal labs.

Discontinue treatment for AST/ALT >5x ULN or bilirubin > 3x ULN

Discontinue treatment for prolonged lymphopenia (<500/mcL) lasting 1 week or longer

Required labs to be drawn by: Horizon Infusions Referring physician

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