



Location
 Camillus
 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)

<p>Initial Maintenance</p> <p>Initial Dose: Administer 2mg/kg IV over 30 minutes at week 0 and 4; then every 8 weeks thereafter</p> <p>Maintenance Dose: Administer _____ mg at _____ mg/kg IV every _____ week(s)</p> <p>Vital signs per HI Protocol</p> <p>Anaphylaxis & Hydration Management per HI Protocol</p>	<p>PRE-MEDICATIONS N/A</p> <p>Acetaminophen 500mg 650mg 1000mg</p> <p>Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)</p> <p>Diphenhydramine (Benadryl) 25mg 50mg PO IV (requires driver)</p> <p>Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV</p> <p>Prednisone _____ mg PO</p> <p>Other _____</p> <p>POST-MEDICATIONS N/A</p> <p>Acetaminophen 500mg 650mg 1000mg</p> <p>Prednisone _____ mg PO</p> <p>Other _____</p>
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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