Center for Infusion Care
HILLSDALE HOSPITAL
Phone: (517) 212-4336 | **Fax:** (877) 249-1191
hillsdalehospital.com/infusion

☐ **STAT REFERRAL**

GASTROENTEROLOGY ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI____ DOB:_____

HT: _____ in WT: _____ kg Sex : ☐ Male ☐ Female Allergies: ☐ NKDA, _____

_____

Physician Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID#:_____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: ICD-10 Code plus Description:_____

PERTINENT MEDICAL HISTORY

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

1) TB test performed? ○ Yes ○ No Date:_____ Results,_____ ***TB testing will be completed per ACR Guidelines and hospital policy.***

2) Patient diagnosed with Congestive Heart Failure? ○ Yes ○ No 3) Liver function test normal? ○ Yes ○ No

4) Patient previously treated with Entyvio OR Remicade OR Simponi Aria? ○ Yes ○ No Please select: ○ Entyvio ○ Remicade ○ Simponi Aria Date: _____

5) Hep-B antigen surface antibody test? ○ Yes ○ No Date: _____

PRESCRIPTION ORDERS:

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY

b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED PER STANDARD PHARMACY CONCENTRATIONS AND HOSPITAL POLICY

c) DOSES MAY BE ROUNDED TO NEAREST VIAL SIZE WITHIN 10% OF PRESCRIBED DOSE. WEIGHT BASED DOSING WILL REMAIN FOR DURATION OF ORDER UNLESS WEIGHT CHAGES +/- BY _____%

SELECT	DOSING OPTIONS	DOSE	ROUTE	FREQUENCY (POPULATE BELOW)	DURATION
☐	**ENTYVIO (LOADING DOSES)**	**300 mg**	**IV**	**0, 2, 6 WEEKS, THEN ONCE EVERY 8 WEEKS**	
☐	**ENTYVIO (MAINTENANCE DOSE)**	**300 mg**	**IV**	**ONCE EVERY 8 WEEKS**	
☐	☐ **REMICADE** / ☐ **INFLECTRA** (SELECT ONE) **LOADING DOSES**	____**mg X** ____**kg**= _____mg	**IV**	**0, 2, 6 WEEKS, THEN ONCE EVERY _____ WEEKS** **RATE:** ☐ **RAPID** or ☐ **STANDARD**	
☐	☐ **REMICADE** / ☐ **INFLECTRA** (SELECT ONE) **MAINTENANCE DOSES**	____**mg X** ____**kg**= _____**mg**	**IV**	**ONCE EVERY _____ WEEKS** **RATE:** ☐ **RAPID** or ☐ **STANDARD**	
☐	☐ **REMICADE** / ☐ **INFLECTRA** (SELECT ONE) **FLAT DOSE**	_____**mg**	**IV**	**ONCE EVERY _____ WEEKS** **RATE:** ☐ **RAPID** or ☐ **STANDARD**	

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE
☐	**NONE**	**NA**	**NA**
☐	**BENADRYL**		
☐	**ACETAMINOPHEN**		
☐	**OXYGEN**		
☐	**SOLU-MEDROL**		
☐	**Other:**		
☐	**Other:**		
☐	**Other:**		
☐	**Other:**		
☐	**Other:**		
☐	**Other:**		

LABS

SELECT	LAB REQUESTED	WHEN	FREQUENCY
☐	**NONE**	**NA**	**NA**
☐	**BMP**	☐ **PRIOR** ☐ **POST**	
☐	**CMP**	☐ **PRIOR** ☐ **POST**	
☐	**BUN/CREATININE**	☐ **PRIOR** ☐ **POST**	
☐	**CRP**	☐ **PRIOR** ☐ **POST**	
☐	**ESR**	☐ **PRIOR** ☐ **POST**	
☐	**ALT**	☐ **PRIOR** ☐ **POST**	
☐	**AST**	☐ **PRIOR** ☐ **POST**	
☐	**LIVER PANEL**	☐ **PRIOR** ☐ **POST**	
☐	**VECTRA**	☐ **PRIOR** ☐ **POST**	
☐	**OTHER:**	☐ **PRIOR** ☐ **POST**	

NOTES/INSTRUCTIONS/COMMENTS

_____

Physician's Signature _____**Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Cosignature (If Required)_____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.