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 PROTOCOL

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 PERSCRIBED DOSE. WEIGHT BASED DOSING WILL REMAIN FOR DURATION OF ORDER UNLESS WEIGHT CHANGES +/- 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 (CIRCLE ONE) LOADING DOSES	___ MG / ____KG= _____ MG	IV	0, 2, 6 WEEKS, THEN ONCE EVERY _____ WEEKS RATE: RAPID or STANDARD	
	REMICADE / INFLECTRA (CIRCLE ONE) MAINTENANCE DOSES	___ MG / ____KG= _____ MG	IV	ONCE EVERY _____ WEEKS RATE: RAPID or STANDARD	
	REMICADE / INFLECTRA (CIRCLE 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.