SHERIDAN COMMUNITY HOSPITAL
OUTPATIENT INFUSION CENTER
PHONE: 989.291.6295 FAX: 877.249.1191

☐ **STAT REFERRAL**

GASTROENTEROLOGY ORDER FORM

PATIENT INFORMATION

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

HT: _____ in WT: _____ ☐ lbs ☐ 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,_____

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) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE

c) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED FOLLOWING HOSPITAL POLICY

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	
☐	RENFLEXIS (LOADING DOSES)	_____mg / kg	IV	0, 2, 6 WEEKS, THEN ONCE EVERY _____ WEEKS	
☐	RENFLEXIS (MAINTENANCE DOSES)	_____mg / kg	IV	ONCE EVERY _____ WEEKS	
☐	OTHER:	_____mg / kg	IV	ONCE EVERY _____ WEEKS	

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.