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

☐ **STAT REFERRAL**

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

3) Patient previously treated with any of the following: (please select) ○ Remicade ○ Inflectra ○ Simponi Aria ○ Benlysta ○ Rituxan ○ Orencia ○ Actemra ○ Stelara, 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 FOLLOWING HOSPITAL POLICY

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

IF LOADAING DOSES HAVE BEEN INITIATED, LIST DOSE IN CYCLE TO BE GIVEN:_____

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
☐	**Actemra**	_____mg/kg	IV	Every_____Weeks	
☐	**Benlysta Loading Dose(s)**	10 mg / kg	IV	0, 2, 4 Weeks, Then Once Every 4 Weeks	
☐	**Benlysta Maintenance Dose**	10 mg / kg	IV	Once Every 4 Weeks	
☐	**Krystexxa**	8 mg	IV	Once Every 4 Weeks	
☐	**Orencia Loading Dose(s)**	_____ mg	IV	0, 2, 4 Weeks, Then Once Every 4 Weeks	
☐	**Orencia Maintenance Dose(s)**	500 mg	IV	Once Every 4 Weeks	
☐	**Orencia Maintenance Dose(s)**	750 mg	IV	Once Every 4 Weeks	
☐	**Orencia Maintenance Dose(s)**	1000 mg	IV	Once Every 4 Weeks	
☐	**Remicade Loading Dose(s)**	_____mg / kg	IV	0, 2, 6 Weeks, Then Once Every_____Weeks	
☐	**Remicade Maintenance Dose(s)**	_____mg / kg	IV	Once Every_____Weeks	
☐	**Rituxan**	_____mg / kg	IV	Once Every_____Weeks	
☐	**Simponi Aria**	_____mg / kg	IV	Once Every_____Weeks	
☐	**Stelara Loading Dose(s)** **SC administration is NOT covered Outpatient*	_____mg	IV	Once	1

PREMEDS

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

LABS

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

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

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

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