

**SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
 GASTROENTEROLOGY ORDER FORM**

STAT REFERRAL

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: _____
 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 MEDIPOINTS / 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 PRESCRIBED DOSE. WEIGHT BASED DOSING WILL REMAIN UNLESS WEIGHT CHANGES +/- BY _____ %
 d) BIOSIMILAR EQUIVALENT RENFLEXIS SUBSTITUTION MAY APPLY

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