Gastroenterology Referral Form

Phone 405.548.4848 **Toll Free** 888.848.4588 **Fax** 405.418.4442

PATIENT INFORMATION

Patient Name:	Date of Referral:	
Address:	SSN:	Gender:
City, State, Zip:	DOB:	Age:
Caregiver Name (if other):	Relationship:	Phone:
Emergency Contact:	Relationship:	Phone:
Primary Insurance Subscriber:	Primary Language:	
Policy #: Group #:	Phone #:	
Insurance Phone:	Work Phone #:	

PRIMARY DIAGNOSIS

- ☐ K50.00 - Regional enteritis, small intestine (Crohns)
- ☐ K50.10 - Regional enteritis, large intestine
- ☐ K50.80 - Regional enteritis, sm & lrg intestine
- ☐ K50.90 - Regional enteritis, unspecified site
- ☐ K51.913 - Ulcerative colitis with fistula
- ☐ K51.918 - Ulcerative colitis unspecified with other complications
- ☐ K51.90 - Ulcerative colitis without complications
- ☐ K60.3 - Anal fistula
- ☐ K63.2 - Intestinal fistula, exclude rectum & anus
- ☐ Other - Please indicate ICD10-CM code & description:_____

_____

Date of diagnosis or years with disease:_____

_____

Please attach and fax
1. Insurance card(s) and demographic information
2. Recent clinical assessment note or H&P
3. Current medication list

MEDICAL HISTORY

Patient Allergies: ☐ NKDA

☐ Yes, listed:_____

Ht:_____ ☐ in ☐ cm Date Taken:

Wt:_____ ☐ lbs ☐ kg _____

Other Medical History:
- ☐ Diabetes ☐ CNS Disorder
- ☐ CHF: consult present physician
- ☐ Current infection
- ☐ Immunosupressive Therapy
- ☐ Inhibits region endemic for bacterial, mycobacterial or fungal infection

DNR: ☐ Yes ☐ No

TB Status:
- ☐ (-)byPPD & date:_____
- ☐ (-)CXR & date:_____
- ☐ Active TB
- ☐ Unknown
- ☐ If (+) treatment taken: ☐ Y ☐ N
- ☐ OptionOne to do PPD or draw Quantiferon

CURRENT MEDICATIONS

_____

_____

_____

_____

_____

PRESCRIPTION AND ORDERS

Did patient receive other therapies in the last 6 months? ☐ Yes ☐ No If yes, date:_____

Is this the first dose? ☐ Yes ☐ No If no, first dose given? _____ ☐ Start ASAP ☐ First/next dose due? _____

Medication	Dose/Frequency	Premedication
☐ Remicade® ☐ Inflectra ☐ Other:	☐ Induction dose: IV at 5mg/kg at 0, 2, 6, then every 8 weeks. ☐ Maintenance dose: IV at 5mg/kg every 8 weeks. ☐ Other: ☐ Infuse _____ mg/kg _____ every _____ for duration _____ ***Titrated rate over minimum of 2 hrs unless otherwise noted.** ☐ Other titrated rate:_____	☐ Methylprednisolone (Solu-Medrol®) 60mg IV ☐ Acetaminophen ☐ 500mg or ☐ 1000mg orally 30 min before infusion ☐ Diphenhydramine ☐ 25mg or ☐ 50mg orally 30min before infusion ☐ Other: _____
☐ Stelara®	**Dose/Frequency** **For patients 55kg or less, administer:** ☐ Induction dose of 260mg IV x 1 dose **For patients 55kg-85kg, administer:** ☐ Induction dose of 390mg IV x 1 dose **For patients >85kg, administer:** ☐ Induction dose of 520mg IV x 1 dose ☐ Maintenance dose: 90mg subcutaneously every 8 weeks	
☐ Entyvio®	☐ Induction dose: Initial dose of 300mg infused over 30 mins at week 0, 2, 6, then every 8 weeks ☐ Maintenance dose: 300 mg infused over 30 mins every 8 weeks	
☐ Other:		

Lab orders: ☐ CBC and hepatic panel every 6 months ☐ Other:_____

Adverse and Anaphylactic Reactions will be treated per OptionOne protocol.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment	***Signature:*** ***Date:***

PHYSICIAN INFORMATION

Name:		Hospital/Clinic:
Address:		Office Contact:
City, State, Zip:		Phone: Fax:
NPI:	UPIN:	License #: