SEMINOLE HOSPITAL DISTRICT
INFUSION CENTER
Phone: 432-758-4716 Fax: 877-249-1191

☐ **STAT REFERRAL**

GASTROENTEROLOGY ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):_____

_____

Provider 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? O Yes O No Date:_____ Results,_____

2) Patient diagnosed with Congestive Heart Failure? O Yes O No 3) Liver function test normal? O Yes O No

4) Patient previously treated with Entyvio OR Remicade OR Simponi Aria? O Yes O No Please select: O Entyvio O Remicade O Simponi Aria Date: _____

5) Hep-B antigen surface antibody test? O Yes O No Date: _____

PRESCRIPTION ORDERS:

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SALINE PER HOSPITAL PROTOCOL PRN UNLESS OTHERWISE NOTED BY PROVIDER

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 TO REMAIN UNLESS WEIGHT CHANGES +/- BY____ %

d) BIOSIMILAR EQUIVALENT 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		
	SOLU-MEDROL		
	Other:		
	Other:		
	Other:		
	Other:		
	Other:		
	Other:		
	OXYGEN:		

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.