Infusion Referral Form

Please include the following information

1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes & Labs
3. TB screening & Hepatitis B vaccine or testing documentation

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Patient Name: _____DOB: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone Number: Cell: _____ Other: _____

Diagnosis codes : □ Ulcerative Colitis: (Dx code) _____ □ Crohn's Disease:(Dx code) _____

□ Psoriasis: (Dx code)_____ □ Other (Dx code) _____

□ Iron: Venofer is preferred product for most insurances. **Requires a primary diagnosis of iron deficiency and an underlying condition, UNLESS pregnancy related.** Examples: malabsorption to oral iron, CKD, Crohn's disease, ulcerative colitis, heavy menstrual bleeding.

* Underlying condition/diagnosis: _____

* Has patient tried and failed oral iron? Yes ___ No ___

* Does the patient currently see a GI physician? Yes ___ No ___

* Do you want a consult for iron deficiency? Yes ___ No ___

Prescription Orders: □Remicade □ Stelara □ Entyvio

□ Initial Dosing, Biologics : _____mg/kg IV on day 0, 2 weeks, 6 weeks then every_____ weeks

Pre-Medications:

□ Acetaminophen 650mg □ Benadryl 25 mg IVP/PO

□ Benadryl 50mg IVP/PO □ Solu-Medrol 40mg IVP

□ Solu-Medrol 125mg IVP □ Other: _____

Date of last labs: _____ Please attach

Physician Signature, written name & Practice

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