

FAX

To: Upstate HomeCare Intake

Fax#: (315) 580-4297

Patient Name:

Date of Birth:

Allergies:

Wgt:

Referral Checklist - Please Attach the Following

Demographics/Insurance

H&P/Progress Notes/Labs/Medication Profile/Failed Therapies

Diagnosis Information / Medical Assessment

Diagnosis: Crohn's Disease Ulcerative Colitis Other _____

Has patient received a PPD (tuberculosis) Skin Test or QuantiFeron TB GOLD Test? Yes Results: _____
Prior to initiating treatment and periodically during therapy, patient should be evaluated for active tuberculosis and tested for latent infection. No

Prescription Information

1. Assess patient for signs/symptoms of infection; notify MD if present prior to proceeding

2. Establish Intravenous Access (Peripheral IV) unless patient already has a line (PICC)

3. Infusion Labs: CBC w/differential ESR CMP CRP Other: _____

4. Medication: _____ Dose: _____mg/Kg _____mg IV q _____ x 1 year

Flushing

Flush with 3-5mL of Sodium Chloride 0.9% (10mL flush)

Qty: 30mL Refills: _____

Pre-Meds

PO: Tablets or Elixir - Patient to obtain

Acetaminophen 650mg tablet OR Acetaminophen 160mg/5mL solution _____
(15mg/kg ONCE PO; max dose 650mg)
For oral tablets round the dose to closest 325 or 650mg

Cetirizine (Zyrtec) 5-10mg tablet OR Cetirizine (Zyrtec) syrup (1mg/1mL) _____
Age <6 years old: Dose 5mg / Age >= 6 years old: Dose 10mg

Diphenhydramine (Benadryl) 25-50mg tablets OR Diphenhydramine (Benadryl) 12.5mg/5mL Elixir _____
(1mg/kg ONCE PO; max dose 50mg)

IV: Optional based on clinical scenario

Diphenhydramine 50mg/mL - 1mL vial Qty #1
(1.25mg/kg IV; max dose 50mg) _____
Weight <40 kg: Give 1.25mg/kg / Weight >= 40 kg: Give 50mg

Methylprednisolone 40mg vial Qty #1
(1mg/kg/dose IV; max dose of 40mg) _____
Weight <40 kg: Give 1.25mg/kg / Weight >= 40 kg: Give 50mg

Hydration - 250mL Bag Sodium Chloride 0.9% @ 50mL/hr Qty #1 _____

Anaphylactic Orders: _____

IM Epinephrine [1mg/mL preparation = 1:1000] 1mL vial Qty #1
Give 0.01 mg/kg/dose; IM in mid-outer thigh; may repeat every 5 min for 3 doses
Weight <30 kg: Give 0.01mg/kg/dose / Weight >= 30 kg: Adult dose = 0.3mg = 0.3mL

E-scribe: Upstate HomeCare

Dispense as Written

Substitution Permissible

Ordering Provider: _____

NPI#: _____

Provider Signature: _____

Date: _____

By signing this form, you, as the following physician are authorizing an Upstate HomeCare Pharmacist to transcribe the above order into verbal orders.

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