

Gastroenterology Referral Form

Please send the following with clinical documentation, which includes visit, physical and history notes, plus lab results for last 3 months, to:

p: 844.575.1515 | f: 844.797.5050 | e: specialtyreferrals@soleohealth.com

This form is not a valid prescription

← Please detach before submitting to a pharmacy. Cut or tear here.

PATIENT INFORMATION					
Patient Name			DOB	Contact Phone	
Address		City	State	Zip	
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security, last 4 digits		Weight (lb.)	Height (in.)	
<input type="checkbox"/> NKDA		<input type="checkbox"/> Allergies		Date	
ICD-10 code (required)			ICD-10 description		
Patient Status <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy		TB Skin Test <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B Screen <input type="checkbox"/> Yes <input type="checkbox"/> No		
PRESCRIBER INFORMATION					
Ordering Prescriber			Prescriber NPI		
Practice Name			Phone	Fax	
Practice Address		City	State	Zip	
REQUIRED DOCUMENTATION					
<input type="checkbox"/> Insurance Cards		<input type="checkbox"/> History & Physical		<input type="checkbox"/> Medication List	
<input type="checkbox"/> Most Recent Labs					
GASTROENTEROLOGY TREATMENT PLAN					
<input type="checkbox"/> Remicade® or Biosimilar _____ Loading dose: <input type="checkbox"/> 5mg/kg <input type="checkbox"/> 7.5mg/kg <input type="checkbox"/> 10mg/kg at 0, 2 and 6 weeks, then every _____ weeks thereafter					
<input type="checkbox"/> Entyvio® <input type="checkbox"/> 300 mg infused IV at 0, 2, and 6 weeks, then every _____ weeks thereafter.					
<input type="checkbox"/> Stelara® or Biosimilar _____ 130 mg (5mg/ml) single dose vials for intravenous use :			<input type="checkbox"/> (<=55kg) 260 mg IV over 1 hour x 1 dose <input type="checkbox"/> (55kg to 85 kg) 390 mg IV over 1 hour x 1 dose <input type="checkbox"/> (>85kg) 520 mg IV over 1 hour x 1 dose		
<input type="checkbox"/> Maintenance: Inject 90mg - (2x - 45mg) SC 8 weeks after the initial IV infusion then every 8 weeks thereafter					
<input type="checkbox"/> Skyrizi® <input type="checkbox"/> Crohn's Loading Doses - Infuse 600 mg IV at weeks 0, 4 and 8 <input type="checkbox"/> Ulcerative Colitis Loading Doses - Infuse 1200 mg IV at weeks 0, 4 and 8 Maintenance Dose <input type="checkbox"/> Inject 360 mg SC at week 12 and then every 8 weeks thereafter <input type="checkbox"/> Inject 180 mg SC at week 12 and then every 8 weeks thereafter					
<input type="checkbox"/> Tremfya® <input type="checkbox"/> Ulcerative Colitis and Crohn's Loading Doses - Infuse <input type="checkbox"/> 200 mg IV at weeks 0, 4, 8 <input type="checkbox"/> 400mg SC at weeks 0, 4, 8 Maintenance Doses <input type="checkbox"/> 200 mg SC q 4 wks <input type="checkbox"/> 100 mg SC q 8 wks					
<input type="checkbox"/> Other		Include dosage, frequency and any other special instructions.			
<input type="checkbox"/> Refill for 1 year					
NURSING					
Skilled RN to establish and maintain vascular access as needed, draw ordered labs, conduct patient assessments, and educate on home infusion, medication administration, self-monitoring and safety.					
PREMEDICATION			LABORATORY ORDERS		
<input type="checkbox"/> Include premedication per Pharmacy's infusion protocol.			<input type="checkbox"/> CBC every _____		
<input type="checkbox"/> Other _____			<input type="checkbox"/> CMP every _____		
			<input type="checkbox"/> Other _____		

The Pharmacy may contact the prescriber to comply with state-specific requirements. The prescriber is required to comply with any applicable state-specific prescription requirements (e.g., e-prescribing, prescription forms).

The information in this form is intended only for the person(s) or entity to which it is addressed and may contain confidential or legally protected material. If you receive this information in error, please contact the sender and destroy the document(s) promptly at the direction of the sender.