

Gastroenterology Referral Form
PATIENT INFORMATION
PROVIDER INFORMATION

 Name _____ DOB _____
 Address _____
 City _____ State _____ Zip _____
 Phone _____ Alt. Phone _____
 Email _____ Gender M F

 Name _____ NPI _____
 Address _____
 City _____ State _____ Zip _____
 Phone _____ Fax _____
 Office Contact _____ Phone _____

REQUIRED Insurance Card Front/Back Prescription Insurance Card Front/Back Clinical Notes Lab/Test Results

CLINICAL INFORMATION

 ICD-10 _____ Diagnosis Description _____
 Drug Allergies _____ Latex Allergy Yes No
 Height _____ (in) Weight _____ (lbs) TB/PPD Test Given Yes No Hepatitis B Vaccination: Yes No
 Line Access PIV Port PICC Midline Initial Infusion Yes No (If no, date of last infusion _____)

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Entyvio (vedolizumab)	<input type="checkbox"/> 300mg Vial	Starting Dose: Infuse 300mg IV over 30 minutes at week 0, 2, and 6 Maintenance Dose: Infuse 300mg IV over 30 minutes every 8 weeks	3 Doses	None
<input type="checkbox"/> Remicade (infliximab) <input type="checkbox"/> Inflectra (infliximab-dyyb) <input type="checkbox"/> Renflexis (infliximab-abda) <input type="checkbox"/> Avsola (infliximab-axxq)	<input type="checkbox"/> 100mg Vial	<input type="checkbox"/> Starting Dose: Infuse _____mg/kg at week 0, 2 and 6 <input type="checkbox"/> Starting Dose: Infuse _____mg at week 0, 2 and 6 <input type="checkbox"/> Maintenance Dose: Infuse _____mg/kg IV every 8 weeks <input type="checkbox"/> Maintenance Dose: Infuse _____mg IV every 8 weeks	3 Doses	None
<input type="checkbox"/> Stelara (ustekinumab)	<input type="checkbox"/> 130mg/26ml Syringe <input type="checkbox"/> 90mg Syringe	<input type="checkbox"/> Starting Dose: Infuse 260mg IV per manufacturer's guidelines x 1 <input type="checkbox"/> Starting Dose: Infuse 390mg IV per manufacturer's guidelines x 1 <input type="checkbox"/> Starting Dose: Infuse 520mg IV per manufacturer's guidelines x 1 Maintenance Dose: Inject 90mg SQ every 8 weeks thereafter**	1 Dose	None
<input type="checkbox"/> Skyrizi (risankizumab-rzaa)	<input type="checkbox"/> 600mg/10ml Vial	Infuse 600mg IV at week 0, 4 and 8, then begin maintenance dose** of 360mg SC at week 12 and every 8 weeks thereafter	3 Doses	None
<input type="checkbox"/> Other:				

PRE-MEDICATION	DOSE/STRENGTH	DIRECTIONS
<input type="checkbox"/> Acetaminophen	500mg	Take 1-2 tablets PO prior to infusion or post-infusion as directed
<input type="checkbox"/> Cetirizine	10mg	Take 1 tablet PO prior to infusion or as directed
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 25mg IV/PO <input type="checkbox"/> 50mg IV/PO	Take 1 tablet PO prior to infusion or as directed OR Inject contents of 1 vial IV prior to infusion or as directed
<input type="checkbox"/> Methylprednisolone	<input type="checkbox"/> 40mg <input type="checkbox"/> 125mg	Inject contents of 1 vial IV prior to infusion or as directed
<input type="checkbox"/> Ondansetron ODT	4mg	Take 1-2 tabs prior to infusion or as directed
<input type="checkbox"/> Other		

Special Instructions:

My signature below certifies that (1) The above-named individual is my patient and the therapy identified has been deemed medically necessary. (2) All information provided is true and accurate to the best of my knowledge. (3) I authorize the use of BrookWell Health's Infusion and line access and flushing protocols. (4) I authorize BrookWell Health to substitute the approved biosimilar if required / allowed by insurance coverage. (5) I authorize BrookWell Health to perform any necessary emergency and/or anaphylaxis treatment as per BWH protocol (*see reverse). **Maintenance dose must be filled at a Specialty Pharmacy.

Provider Name _____ Provider Signature _____ Date _____

Adverse Reaction Management Protocol

Hypersensitivity reaction including, but not limited to, fever, rash, itching, rigors, sneezing, nausea and vomiting

If reaction occurs:

- If indicated, stop infusion
- Maintain / establish vascular access
- May utilize the following PRN medications as follows:
 - * Allergies, hives, itching - Diphenhydramine 25-50mg PO/IV as a single dose, may repeat with either medication if needed
 - * Nausea, vomiting, heartburn - Ondansetron 4mg ODT (may repeat in 20 minutes if nausea continues) or Famotidine 20mg PO as a single dose; if severe - give Ondansetron 4mg slow IVP (may repeat in 20 minutes if nausea continues) or Famotidine 20mg slow IVP
 - * Headache, pain or fever > 100.4°F - Acetaminophen 500mg 1-2 tablets PO as a single dose or Ibuprofen 400mg PO as a single dose
 - * Hypotension (90/60) - place patient in reclined position, administer 0.9% NaCl IV 500ml, may repeat to keep BP > 90/60, monitor vital signs
 - * Hypertension (> 30mmHg above baseline or > 180mmHg SBP) - Clonidine 0.1mg and wait 45 minutes, may administer amlodipine 5mg if hypertension persists
 - * Chest pain/discomfort or shortness of breath - Oxygen 2-15 liters, titrate to keep SPO₂ ≥ 92%
 - * May give Famotidine 20mg IV or Methylprednisolone 125mg IM/IV - refractory to other treatments given
- May resume infusion when symptoms resolve at 50% previous rate and increase per manufacturer guidelines

Severe allergic/anaphylactic reaction management

- Obtain a thorough allergy and drug history, note any cross-sensitivity
- Identify risk factors for anaphylaxis including history of severe drug reactions and family history of same, when administering blood/blood components and the first dose of an infusion medication.
- Identify and respond to signs/symptoms of anaphylaxis which is the likely type of reaction when all of the following criteria are met:
 - * Sudden onset and progression of symptoms
 - * Life-threatening airway / breathing / circulatory symptoms, such as laryngeal edema, stridor, severe dyspnea / wheezing, confusion, signs of shock, tachycardia, hypotension, cardiac arrest
 - * Skin changes or changes in mucosa, such as flushing urticaria, angioedema
- Symptoms associated with less severe systemic reactions may include
 - * Neurological - dizziness, headache, weakness, syncope, seizures
 - * Psychiatric - anxiety
 - * Respiratory - dyspnea, wheezing, bronchospasm, tachypnea
 - * Cardiovascular - tachycardia, hypotension, arrhythmias
 - * Cutaneous - flushing erythema, pruritis, urticaria, angioedema
- Interventions
 - 1) Stop infusion immediately
 - 2) Discontinue any medication suspected of causing reaction
 - 3) Initiate basic life support as needed
 - * Initiate rapid response team, "Code"
 - 4) Utilize the 'Emergency Management of Anaphylaxis' in the Reaction Management Kit to follow steps for correct management of reaction.
 - 5) Perform interventions and treatments as ordered or according to organizational protocol
 - 6) Administer emergency medications - medications will include
 - * Epinephrine
 - * Corticosteroids - methylprednisolone 40mg or 125mg IM/IV
 - * Antihistamines - Diphenhydramine 25 - 50mg IM/IV
 - * IV fluids - 0.9% NaClResuscitation equipment will include
 - * Barrier mask for CPR
 - * Self-inflating bag for CPR maskBreathing support
 - * Oxygen and delivery system or device
 - 7) Monitor patient's vital signs. Monitor and observe patient for at least 6 hours
 - 8) Patient may require transfer to ER department for observation period
- Documentation - document in the patient's health record
 - * Presence of allergies/reactions
 - * Observations and patient assessment
 - * Licensed practitioner notification
 - * Interventions taken and outcome
 - * Patient condition and response to interventions