Open 365 Days A Year • 8am - 8pm • By Appointment | **801.577.7055** | **888.717.7578**

REFERRAL STATUS		LOCATION			
New Referral	Order Renewal	Murray	Tooele	Layton	St. George

PATIENT INFORMATION

PATIENT NAME:		DOB:	SEX: M F
WEIGHT: LBS KG		PHONE NUMBER:	
ALLERGIES:		EMAIL:	
Please check that the following are included:	Patient demographics and insurance attached	Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached	
	Current Medication List:		

DIAGNOSIS

ICD-10 CODE:	OTHER:	DATE OF LAST INFUSION/INJECTION:

PHYSICIAN INFORMATION

PHYSICIAN NAME:	PHONE NUMBER:
PRACTICE NAME:	FAX NUMBER:
OFFICE CONTACT:	

MEDICATION ORDER

MEDICATION:	INITIAL DOSE:	FREQUENCY:	NOTES/COMMENTS:
Stelara (ustekinumab)	Infuse ______ mg IV over 1 hour Inject ______ mg MAINTENANCE DOSE: Inject ______ mg SQ	Initial IV Dose: x 1 Inital SQ Injection: Once and repeat 4 weeks later Maintence Dose: Every ______ weeks	

PHYSICIAN SIGNATURE ______________________________	DATE (Order is Valid for One Year) ______________

LAB ORDERS

CMP	CBC	CRP	ESR	Other ______________
Labs to be Drawn by Infusion Center		Frequency ______________		Standing Order? Yes No

TYPES OF ACCESS

Peripheral	PICC	Midline	Port	Subcu	I/M