Phone: 1-800-277-7302 Fax: 1-866-374-6663 Email: intake@healthcoga.com ***Initial order ☐ Reorder ☐***

Demographics Information: Today's Date ___________________
Patient Name: ____ DOB: ___________________________

Address: ____ City: __________________ State: GA Zip: _________

Phone #: ______________________________ ☐ Cell Alternate Phone #: ___________________________ ☐ Cell

Height:_______ in/ft Weight: _______ lbs/kg Date weight recorded: _________ Last 4 of SSN: ____________

Allergies: ____ ☐ **NKDA**

Diagnosis Information: ☐ Crohn's of small intestine w/o complications K50.00 ☐ Crohn's disease of large intestine without complications K50.10 ☐ Crohn's of small and large intestine without complications K50.80 ☐ Ulcerative Colitis without complications K51.90 ☐ Other Diagnosis/ICD10Code____

Date Infusion to Begin: ______________________

Previous Infusion Reaction: ☐ YES ☐ NO

List Reactions: ____________________________

Is this a first infusion? ☐ YES ☐ NO

Date of Last Infusion: ______________________________

List of Failed Therapies: ____________________________

Assessment Questions: *Please Provide Appropriate Documentation*
Diabetes? ☐ Yes ☐ No HTN? ☐ Yes ☐ No Cardiac History? ☐ Yes ☐ No Difficulty Breathing? ☐ Yes ☐ No
Requires Oxygen? ☐ Yes ☐ No Confusion /Disorientation? ☐ Yes ☐ No Neuro History? ☐ Yes ☐ No
Date of Negative TB test: _________________

Medication: ________________________Dose: _____________Route: ___________Frequency: _____________
for ☐ 12 Months or ☐ _______ months

Pre-Medications: Patient to Provide and take 30 minutes prior to infusion. *Will receive 50 ml of 50ml bag of NS post- infusion*.
☐Acetaminophen 325 mg PO x1 ☐Acetaminophen 650 mg PO x1
☐ Benadryl 50mg PO X1 ☐ Benadryl 25 mg Po x1
☐ Other Pre-medication: ___________________________________

Access: ☐ PIV ☐ PORT ☐PICC Route: ☐ IV

Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency

PIV – NS 5ml: Qty 3

PORT – NS 10ml: Qty 3, Heparin 5mL 100units/mL x 1 per infusion.

PICC – NS 10ml:Qty 3, Heparin 5mL 10units/mL x 1 per infusion

Supplies: (please strike through if not required)

Administration Supplies (A4222) – 1 per infusion

Catheter Care Supplies (A4221) – 1 per week

Infusion Pump (E0781)

Nursing services to administer medications

Administer the anaphylaxis protocol for adverse reactions

Provider signature: ____

NPI # _______________________ Phone __________________________ Fax _____________________________

Office Address: ____________________________________ City: _____________________ St ____Zip: _________

Printed MD Name:___________________________________ Contact Name: ______________________________

☐ Demographic information ☐ Patient Ins. Card ☐ H & P ☐ Office notes ☐ Failed therapies in documentation
☐ Up to date medication list

TSP 9/23