INFLECTRA INFUSION ORDER
(infliximab-dyyb)

Date: ____/____/_____

PATIENT INFORMATION

Patient Name:_____ DOB:___/____/____ Phone: _____

Height: _____ Weight _____ lbs / kg

Allergies: _____

Diagnosis: _____ ICD-10: _____

TB Test Date: _____/____/____ Result: _____ Hep B Test Date: _____/____/____ Result: _____

Labs to be drawn by: O Infusion Clinic O Referring Physician

PRE-MEDICATIONS

Benadryl:	O PO	O IV	O 25mg	O 50mg	O PreMed	O PRN
Acetaminophen:	O PO		O 650mg		O PreMed	O PRN
O Zyrtec	O PO		O 10mg		O PreMed	O PRN
Solu-Medrol		O IV	O ____mg		O PreMed	O PRN

INFLECTRA ORDERS

Dose:	O 3mg/kg	O 5mg/kg	O 7.5mg/kg	O 10mg/kg	Total Dose: _____
Frequency:	O Initial Dose at 0, 2, 6 weeks then			O Q4 weeks	OQ6 weeks OQ8 weeks

Infusion Start Date: _____/_____/_____

PROVIDER INFORMATION

Provider's Name: _____ Signature: _____

Phone: _____ Fax: _____ Date: _____/_____/_____

Office Address: _____

Email Address: _____ Contact Person: _____

PLEASE SEND COPY (FRONT AND BACK) OF INSURANCE CARD

PHONE: 972-810-0990 | FAX: 972-810-0994