REMICADE INFUSION ORDER (infliximab)

INFUSIONMED | USA
LIVING YOUR BEST LIFE. ONE DROP AT A TIME.

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

Lab Orders: _____

PRE-MEDICATIONS

Benadryl:	O PO	O IV	O 25mg	O 50mg	O PreMed	O PRN
Acetaminophen	O PO		O 325mg	O 650mg	O PreMed	O PRN
Zyrtec:	O PO		O 10mg		O PreMed	O PRN
Solu-Medrol:		O IV	O ____mg		O PreMed	O PRN
Normal Saline Bolus:		OIV	O ____mg		O PreMed	O PRN
Zofran:	O PO	O IV	O ____mg		O PreMed	O PRN

BENLYSTA ORDERS

O 3mg/kg O 5mg/kg O 7.5mg/kg O 10mg/kg Next Dose: ___/___/___

O Round to nearest vial (100mg per vial) OR O Total Dose = _____mg

Frequency: O Initial dose at 0, 2, 6 weeks, **THEN** O Q 4 weeks O Q 6 weeks O Q 8 weeks

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