

RENFLIXIS INFUSION ORDER (infliximab-abda)



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: Infusion Clinic Referring Physician

Lab Orders: _____

PRE-MEDICATIONS

Benadryl:	<input type="radio"/> PO	<input type="radio"/> IV	<input type="radio"/> 25mg	<input type="radio"/> 50mg	<input type="radio"/> PreMed	<input type="radio"/> PRN
Acetaminophen	<input type="radio"/> PO		<input type="radio"/> 325mg	<input type="radio"/> 650mg	<input type="radio"/> PreMed	<input type="radio"/> PRN
Zyrtec:	<input type="radio"/> PO		<input type="radio"/> 10mg		<input type="radio"/> PreMed	<input type="radio"/> PRN
Solu-Medrol:		<input type="radio"/> IV	<input type="radio"/> ___mg		<input type="radio"/> PreMed	<input type="radio"/> PRN
Normal Saline Bolus:		<input type="radio"/> IV	<input type="radio"/> ___mg		<input type="radio"/> PreMed	<input type="radio"/> PRN
Zofran:	<input type="radio"/> PO	<input type="radio"/> IV	<input type="radio"/> ___mg		<input type="radio"/> PreMed	<input type="radio"/> PRN

RENFLIXIS (INFLIXIMAB-ABDA) ORDERS

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

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

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