CONSULTANTS INC
SPECIALIZING IN INFECTIOUS DISEASES

Ambulatory Infusion Center

Parkway Medical Center
3609 Park East Drive #207
Beachwood, OH 44122

216-360-0456 TEL
216-378-9824 FAX
216-360-9449 ALT FAX

INFUSION ORDERS - REMICADE (infliximab)

Date of Referral: _____ Infusion Location: ☐ Beachwood ☐ Middleburg Heights ☐ Painesville

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ WT (kg): _____ HT (in): _____

Diagnosis: _____ ICD10 Code: _____

Allergies: _____

PLEASE FAX SUPPORTING CLINICAL DOCUMENTATION, INCLUDING MEDICAL RECORDS/PROGRESS NOTES, LABS, and INSURANCE INFORMATION (both front and back of the card) ALONG WITH THIS FORM

REMICADE DOSING

☐ Remicade dose of 3 mg/kg
☐ Remicade dose of 5 mg/kg
☐ Remicade dose of 7.5 mg/kg
☐ Remicade dose of 10 mg/kg
☐ Round to the nearest 100 mg
☐ Remicade specific dose of _____

Frequency:
☐ Loading dose on day 0, 2 weeks, 6 weeks, and every 8 weeks thereafter
☐ Specific dose frequency of_____

☐ Premed Orders: _____

☐ Special Needs/Considerations: _____

Date of last TB test: _____ Result: _____
If positive, Date of Negative Chest X-ray: _____
Date of Hep B Screen: _____ Result: _____
Date of Hep B Surface Antigen (HBsAg): _____ Result: _____
Date of Hep B Surface Antibody (HBsAb/anti-HBs): _____ Result: _____
Date of Hep Core Antibody Total (HBcAb/anti-HBc): _____Result: _____

Prescribing Physician: _____
Address: _____
Physician Signature: _____ Date: _____
Physician Phone: _____ Fax: _____

LAB REQUIREMENTS and LAB MONITORING ARE THE RESPONSIBILITY OF THE PRESCRIBING PHYSICIANS