Remicade Infusion Order

LivWell INFUSIONS

Fax 888 511-7654 Phone 888 864-7341

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:

- ◯ K50.90 Crohn's disease, unspecified, without complications
- ◯ K51.90 Ulcerative colitis, unspecified, without complications
- ◯ M05.79 Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement
- ◯ M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites
- ◯ M06.9 Rheumatoid arthritis, unspecified
- ◯ Other _____

ICD-10 _____

Patients weight: _____

Lab Date: _____

Allergies: _____

ALSO INCLUDE...

- ◯ Clinical/ Progress Notes
- ◯ Demographics Sheet
- ◯ Current Medications
- ◯ Labs

REMICADE ORDER

Patients Weight: _____ kg

Remicade Dose:

- ◯ Initial/Reload Dosing: _____mg/kg IV on day 0, 2 weeks, 6 weeks then every _____ 6 or 8 weeks.
- ◯ Maintenance Dosing: _____ mg/kg IV every _____ 6 or 8 weeks.

5mg/kg 3mg/kg other: _____ mg/kg

PreMeds:

- ◯ Benadryl 50mg IV
- ◯ APAP 500 mg PO
- ◯ Famotidine 20mg IV
- ◯ Benadryl 50 mg PO

Date of last Remicade Infusions: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____