Remicade

(infliximab)

Infusion Order

CIVIC INFUSION

249 Danbury Rd. Wilton, CT 06897
400 Columbus Ave, Valhalla, NY 10595
127Washington Ave, North Haven, CT 06473
220 Farmington Ave, Farmington, CT 06032

Patient Name: _____ DOB: ____/____/_____ M ○ F ○

Allergies: _____ Phone: _____

Diagnosis: _____ ICD- 10: _____

Please fax a copy of the following patient information:

☐ Recent progress Note ☐ Current CBC & CMP ☐ TB & Hep B Results *(upon initiation)*

TB test date: ____/____/_____ Result: _____ *(can be PPD skin test or QuantiFERON TB gold blood test)*

Hep B (HBsAg and anti- HBV) test date: ____/_____/_____ Result: _____

PRE- MEDICATION

☐ Acetaminophen 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ No Pre-med
☐ Solu- Medrol 125mg IVP
☐ Solu- Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
Other: _____

REMICADE ORDERS / IV DOSAGE

○ _____ mg/kg *weight-based* Patient Weight: _____ lbs / kg

○ _____ mg *flat-dosed* Height: _____ft_____in

FREQUENCY

○ at weeks 0, 2 and 6, then every 8 weeks *(induction)* ***OR*** ○ every _____ weeks *(continuation)*

NOTES:

_____

Provider's Name: _____ Signature**:** _____

NPI: _____ Date: _____ Ph: _____ Fax: _____