LifeCare INFUSION

6415 Fort Apache Road, Suite #175
Las Vegas, NV 89148
Phone: 702-665-5730
Fax: 702-780-4887

REMICADE (infliximab) **infusion orders**

Patient Name: _____ Date of Birth: _____
Address: _____ Phone Number: _____
Gender: _____ Height: _____ Weight: _____ (lb./kg)

Diagnosis

☐ ____ Rheumatoid Arthritis
☐ ____ Psoriatic Arthritis
☐ ____ Plaque Psoriasis
☐ ____ Ankylosing Spondylitis
☐ ____ Crohn's Disease
☐ ____ Ulcerative Colitis
☐ _____

Pre-Medication

☐ Tylenol 1000mg PO
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Solu-Medrol 125 IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____
☐ _____

Orders

Dosage
☐ _____ mg/kg *weight based*
☐ _____ mg *flat-based*
Frequency
☐ every 0,2, 6, and every 8 weeks (induction)
☐ every _____ weeks _____ Refills

Notes

_____

_____

_____

Ordering Provider

Signature: _____ Date: _____
Provider: _____ Phone: _____ Fax: _____
Address: _____
NPI: _____ DEA: _____