Rituxan Order
(Rituximab)

SMART CHOICE INFUSION
FOR YOUR HEALTH & WELLNESS

www.smartchoiceinfusion.com
Ph: 818-659-8990
Fax: 818-659-8990

Date: _____ Treatment Location: _____

***Please fax a copy of the following patient information:** ❒ Demographics ❒ Insurance Information ❒ Current Medications ❒ H & P Relevant to the Diagnosis ❒ Current CBC & CMP ❒ TB Results ❒ Hep B Results

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ ◯ lbs / ◯ kg Height: _____

Diagnosis: _____

ICD-10: _____

TB Test Date: _____ Result: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: ( ) - Fax: ( ) -

Office Address: _____

Contact Person: _____

Contact Email: _____

Hep B Date: _____

Is patient on any antihypertensive meds that will need to be held 12 hrs prior to infusion? ❒ No ❒ Yes

PRE-MEDICATIONS:

Benadryl:	❒ PO	❒ IV	❒ 25mg	❒ 50mg	❒ Pre-med	❒ PRN
Acetaminophen:	❒ PO		❒ 650mg		❒ Pre-med	❒ PRN
Zyrtec:	❒ PO		❒ 10mg		❒ Pre-med	❒ PRN
Solu-Medrol:		❒ IV	❒ 125mg		❒ Pre-med	❒ PRN
Normal Saline:		❒ IV	❒ 250mL	❒ 500mL		❒ PRN

RITUXAN (RITUXIMAB) IV DOSAGE

Date of Last Treatment, If Continuation:

Dose: _____ **Frequency:** _____

Start Date of Infusion: _____