Remicade Order

(infliximab)

SMART CHOICE INFUSION
FOR YOUR HEALTH & WELLNESS

www.smartchoiceinfusion.com
Ph: 818-659-8182
Fax: 818-659-8990

Date: _____ Treatment Location: _____

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

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: _____

PRE-MEDICATIONS:

Benadryl:	❒ PO	❒ IV	❒ 25mg	❒ 50mg	❒ Pre-med ❒ PRN
Acetaminophen:			❒ 325mg	❒ 650mg	❒ Pre-med ❒ PRN
Zyrtec:			❒ 10mg		❒ Pre-med ❒ PRN
Solu-Medrol:		❒ IV	❒ mg		❒ Pre-med ❒ PRN
Dexamethasone:		❒ IV	❒ 10mg	❒ 5mg	❒ Pre-med ❒ PRN

REMICADE (INFLIXIMAB) IV DOSAGE:

Date of Last Treatment, If Continuation:

❒ 3 mg/kg ❒ 5 mg/kg ❒ 7.5 mg/kg ❒ 10 mg/kg

❒ Round to the nearest viral (100gm per vial)
❒ Pediatric; weight based dosing per visit

OR ❒ Total dose = _____ mg

Frequency: ❒ Initial dose at 0, 2, 6 weeks, then ❒ Q 4 weeks ❒ Q 6 weeks ❒ Q 8 weeks

Next dose due: _____