Sarah Bush Lincoln

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Moderate to Severe Ulcerative Colitis	ICD 10 Code: K51.90
☐ Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90
☐ Rheumatoid Arthritis	ICD 10 Code: M06.9
☐ Ankylosing Spondylitis	ICD 10 Code: M45.9
☐ Psoriatic Arthritis	ICD 10 Code: L40.52
☐ Plaque Psoriasis	ICD 10 Code: L40.0
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION

☐ This signed order form by the provider	☐ Clinical/Progress notes
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ Hepatitis B Test Results: HBsAg, Total HepB Core Antibody	☐ TB Test Results
☐ Pregnancy Test (if applicable)	☐ Hepatitis C Test Rsults
	☐ HIV Screening

List Tried & Failed Therapies, including duration of treatment:

1)

2)

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt (in kg): BMI: **Patient weight required for weight-based orders.

Initial Dosing	☐ Remicade 5mg/kg IV at week 0, 2, 6 then every 8 weeks thereafter
Maintenance Dosing	☐ Remicade 5mg/kg IV every 8 weeks
Alternative Dosing	☐ Remicade _____ IV every _____ weeks

Refills: ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses**

PREMEDICATIONS

☐ Acetaminophen 650mg PO prior to Remicade infusion
☐ Diphenhydramine 25mg PO prior to Remicade infusion
☐ Methylprednisolone 40mg Slow IV Push PRN infusion reaction
☐ Other: _____

Please note: if an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.

ADDITIONAL ORDERS

PRESCRIBER INFORMATION

Prescriber name :		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Ph. 217-258-4150
Suite 204 Fax 217-348-2579
Mattoon, IL 61938

☐ EFFINGHAM
901 Medical Park Dr. Ph. 217-342-7500
Suite 201 Fax 217-342-7499
Effingham, IL 62401

INFUSION ORDERS - REMICADE (INFLIXIMAB)

Clinics Scan to: Physician Orders