



Patient Demographics

Phone: (734) 230-2639

Fax: (248) 243-0583

InfusionCentersofMichigan.com

Patient Name: _____

Patient Phone No: _____

Alternative Phone Number. _____

Patient Insurance: _____ D.O.B. _____

Referring Practitioner: _____ Date: _____

Referring Phone No: _____ Fax No. _____

Referral Status

New Referral

Dose or
Frequency Change

Order Renewal

Location Preference

Macomb Township

48801 Romeo Plank Rd
Ste. 105
Macomb Township, MI

Rochester Hills

1701 E. South Blvd.
Ste. 310
Rochester Hills, MI

East Lansing

1650 Ramblewood Dr.
2nd Floor
East Lansing, MI

Diagnosis: _____

Required Documentation

Patient Demographics

Labs and Tests Supporting Primary
Diagnosis

Insurance Information and
copy of Insurance Card

Signature by Provider

Clinical Progress Notes

Contact Information

All information in this form is strictly confidential and will become part of the patients Medical Record

Contact us at (734) 230-2639 with any questions

Fax this completed form and required documentation to: (248) 844-9768

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| | |
|---------------|----------|
| Patient Name: | DOB: |
| Diagnosis: | DX Code: |
| Allergies: | Ht/Wt: |

| Medication | Dose | Duration/Weeks |
|---|--|--|
| Infliximab IV 0.9% NS per protocol over 2 hours Annual TB test CBC, CMP q 3 months | <input type="checkbox"/> 5mg/kg <input type="checkbox"/> 7.5mg/kg <input type="checkbox"/> 10mg/kg <input type="checkbox"/> _____ Premeds: <input type="checkbox"/> Claritin 10mg PO prior to infusion <input type="checkbox"/> _____ | <input type="checkbox"/> weeks 0, 2, 6 then q 8 weeks <input type="checkbox"/> q 8 weeks <input type="checkbox"/> _____ |
| Entyvio IV 0.9% NS 250 ml over 30 minutes Annual TB test CBC, CMP q 3 months | <input type="checkbox"/> 300 mg Premeds: <input type="checkbox"/> Claritin 10mg PO prior to infusion <input type="checkbox"/> _____ | <input type="checkbox"/> weeks 0, 2, 6 then q 8 weeks <input type="checkbox"/> q 8 weeks <input type="checkbox"/> _____ |
| Stelara IV 0.9% NS 250ml over 1 hour Annual TB test CBC, CMP q 3 months | <input type="checkbox"/> 260mg {<55 kg} <input type="checkbox"/> 390mg {55 kg-85 kg} <input type="checkbox"/> 520mg {>85 kg} | x 1 dose |
| Stelara SQ | <input type="checkbox"/> 90mg SQ every 8 weeks | |
| Venofer CBC w/diff and iron studies after each infusion | <input type="checkbox"/> 100mg/100ml over 15 minutes <input type="checkbox"/> 200mg/100ml over 15 minutes <input type="checkbox"/> 2x 300mg/250 over 1.5 hours + 400mg/250ml over 2.5 hours <input type="checkbox"/> Other | |
| Hydration | <input type="checkbox"/> 0.9% NS <input type="checkbox"/> 1000 ml Over _____ hours | Frequency: _____ x _____ doses |
| Injectafer IV 0.9% NS 100ml over 20 minutes CBC w/diff and iron studies 30 days after 2nd dose. | <input type="checkbox"/> 750mg IV x 2 doses, at least 7 days apart | |
| Ferrlecit IV 0.9% NS 100ml over 90 minutes 1 st dose, then over 60 minutes. CBC w/diff and iron studies before each infusion. | <input type="checkbox"/> 125mg q 4 weeks x 6 doses <input type="checkbox"/> Other Premeds: <input type="checkbox"/> Claritin 10mg PO prior to infusion <input type="checkbox"/> Tylenol 1000mg PO prior to infusion | |
| Skyrizi IV 600 mg given over 1 hour CBC, CMP q 3 months and annual TB test | <input type="checkbox"/> 600mg per dose (3 induction doses weeks 0, 4, 8) <input type="checkbox"/> OBI (6 sub-q doses per year) | |
| Reclast IV 0.9% NS 100ml over 20 minutes Ca >8.5 Creat Clear > 35ml/min within 3 months Dental/Oral exam q 6 mo. | <input type="checkbox"/> 5mg <input type="checkbox"/> Lab draw: CMP Date _____ | <input type="checkbox"/> 1 x/year x 1 dose |
| Prolia Sub-q Injections Dexascan (Initial & most recent) Before infusion patient will need Ca lab value Dental/Oral exam q 6 mo. | <input type="checkbox"/> 60mg Last Dose Date _____ First Dose Date _____ | <input type="checkbox"/> q 6 months <input type="checkbox"/> PA # _____ <input type="checkbox"/> No PA req'd _____ x 2 dose |
| Other | | |

Provider Signature: _____ Date: _____