LAWRENCE COUNTY
Memorial Hospital
DEACONESS ILLINOIS PARTNER

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

DIAGNOSIS AND ICDE 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 (referral will not be processed without the required documentation)

☐ The signed order form by the provider	☐ Clinical/Progress notes (must be within 1 year)\
☐ Patient demographics AND insurance information	☐ Labs and tests supporting primary diagnosis
☐ Prior authorization with reference number	☐ TB Test results (within 1 year)
*Pt may be required to submit a pregnancy test prior to treatment	☐ Hepatitis B results: ABsAG, Total HepB Core Antibody

List of tried and failed therapies, including duration of treatment:

1) _____
2) _____

MEDICATION ORDERS

Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____

Initial Dose	☐ J1745 Remicade 5mg/kg IV at week 0, 2, 6 then every 8 weeks thereafter
Maintenance Dosing	☐ J1745 Remicade 5mg/kg IV every 8 weeks
Alternative Dosing:	☐ J1745 Remicade _____ IV every _____ weeks

Duration: ☐ x6 months ☐ x 1 year ☐ x _____ doses

PREMEDICATIONS/ LAB ORDERS

☐ Acetaminophen _____mg PO PRN
☐ Benadryl _____mg PO or IV
☐ Methylprednisolone _____ slow IV push
☐ Other: _____

☐ CBC ☐ prior to each infusion or ☐ Frequency: _____
☐ CMP ☐ prior to each infusion or ☐ Frequency: _____
☐ Other: _____ Date:_____

ADDITIONAL ORDERS/INFORMATION

PRESCRIBER INFORMATION

Provider Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515
FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS – REMICADE (INFLIXIMAB)