



*Advanced Treatment for Osteoporosis and Inflammatory Diseases*

WHEATON • ROCKVILLE • OLNEY • CHEVY CHASE • FREDERICK • WASHINGTON, DC

## REMICADE (*Infliximab*) INFUSION REFERRAL CHECKLIST

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Referring Office Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Address: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

Dose and frequency: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Please send the following documents and records:

- Patient Demographics – Including preferred contact number for patient
- Copy of the patient's insurance card(s) – Front AND Back
- Remicade order signed and dated by referring physician
- Last two most recent office notes (One must include discussion of Remicade) and consultation note
- Most recent labs that include values for:
  - CMP, CBC, HBV Surface Antigen
  - TB Screening (PPD, QFT Gold or Tspot)
- Medication History
- If this is a continuation of treatment, include the last infusion note

**PLEASE FAX TO 301-424-3590 USING THIS FORM AS THE COVERSHEET**

[www.ariseinfusion.com](http://www.ariseinfusion.com)

CENTRAL CALL CENTER: 240-514-5000

FAX: 301-424-3590