Advanced Treatment for Osteoporosis and Inflammatory Diseases

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

INFLECTRA (*Infliximab-dyyb*) INFUSION REFERRAL CHECKLIST

Patient Name: ____ Date: ___________________

DOB: ______________________

Referring Physician: _____________________________ Referring Office Contact: __________________________

Phone: _________________ Fax: _________________ Address: _____________________________________

Diagnosis: ____ ICD Code: __________________

Dose and frequency: ____

Special Instructions: ____

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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
- Inflectra order signed and dated by referring physician
- Last two most recent office notes (One must include discussion of Inflectra) 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

CENTRAL CALL CENTER: 240-514-5000

FAX: 301-424-3590