



Patient Demographics

Phone: (734) 230-2639
Fax: (248) 844-9768
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: _____