INFUSION CENTERS OF MICHIGAN
Helping you heal one infusion at a time

Phone: (855) 831-0870
Metro Detroit Fax: (248) 844-9768
Lansing Fax: (517) 351-3327
InfusionCentersofMichigan.com

Patient Demographics

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
- ☐ Insurance Information and copy of Insurance Card
- ☐ Clinical Progress Notes
- ☐ Labs and Tests Supporting Primary Diagnosis
- ☐ Signature by Provider

Contact Information

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

Contact us at (855) 831-0870 with any questions

Fax this completed form and required documentation to: Metro Detroit Fax: (248) 844-9768, or Lansing Fax: (517) 351-3327

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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	☐ 5mg/kg ☐ 7.5mg/kg ☐ 10mg/kg ☐ ____________	☐ weeks 0, 2, 6 then q 8 weeks ☐ q 8 weeks ☐ ____________	
	Premeds: ☐ Claritin 10mg PO prior to infusion ☐ ____________		
Entyvio IV 0.9% NS 250 ml over 30 minutes Annual TB test CBC, CMP q 3 months	☐ 300 mg	☐ weeks 0, 2, 6 then q 8 weeks ☐ q 8 weeks ☐ ____________	
	Premeds: ☐ Claritin 10mg PO prior to infusion ☐ ____________		
Stelara IV 0.9% NS 250ml over 1 hour Annual TB test CBC, CMP q 3 months	☐ 260mg {<55 kg} ☐ 390mg {55 kg-85 kg} ☐ 520mg {>85 kg}		x 1 dose
Stelara SQ	☐ 90mg SQ every 8 weeks		
Venofer CBC w/diff and iron studies after each infusion	☐ 100mg/100ml over 15 minutes ☐ 200mg/100ml over 15 minutes ☐ 2x 300mg/250 over 1.5 hours + 400mg/250ml over 2.5 hours ☐ Other		
Hydration	☐ 0.9% NS	☐ 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.	☐ 750mg IV x 2 doses, at least 7 days apart		
Ferrlecit IV 0.9% NS 100ml over 90 minutes 1st dose, then over 60 minutes. CBC w/diff and iron studies before each infusion.	☐ 125mg q 4 weeks x 6 doses	☐ Other	
	Premeds: ☐ Claritin 10mg PO prior to infusion ☐ Tylenol 1000mg PO prior to infusion		
Skyrizi IV 600 mg given over 1 hour CBC, CMP q 3 months and annual TB test	☐ 600mg per dose (3 induction doses weeks 0, 4, 8)	☐ 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.	☐ 5mg ☐ Lab draw: **CMP Date** ____________	☐ 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.	☐ 60mg Last Dose Date ____________ First Dose Date ____________	q 6 months ☐ PA # ____________ ☐ No PA req'd ____________	x 2 dose
Other			

Provider Signature: ______________________________ Date: ____________