

Patient information

Patient name _____

DOB _____

Mobile number _____

Weight _____ kgs lbs

Diagnosis Adult rheumatoid arthritis
 Psoriatic arthritis
 Other _____

Allergies NKDA _____**Medication instructions**

Pre-medications N/A
 Provider prescribed: _____

Medication order

Dose	Frequency
<input type="checkbox"/> 500 mg (patient weight is less than 60 kg)	<input type="checkbox"/> Weeks 0, 2, 4, then every 4 weeks
<input type="checkbox"/> 750 mg (patient weight is between 60 kg to 100 kg)	<input type="checkbox"/> Every 4 weeks
<input type="checkbox"/> 1000 mg (patient weight is more than 100 kg)	<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____	

Medication route IV
 Other _____

Lab order (Include frequency) Please list any labs to be drawn by the infusion clinic:
 N/A

Prerequisites Please include the following with your fax submission: Labs and tests supporting diagnosis | Office / progress notes | Demographics | Negative TB results | Negative Hep B results

Please send to Columbia, MD Silver Spring, MD Bowie, MD Frederick, MD

Referring provider information

Referring provider name _____ NPI _____

Practice name _____

Point of contact Name _____ Email _____ Phone _____

Provider signature _____ Date _____