SPRINGSIDE INFUSION

Stelara & Biosimilars

Patient information

Patient name _____ **DOB** _____

Mobile number _____ **Weight** _____ ☐ kgs ☐ lbs

Diagnosis
N/A
☐ Other _____

Allergies ☐ NKDA ☐ _____

Medication instructions

Pre-medications
☐ N/A
☐ Provider prescribed: _____

Medication order

Dose
☐ 45 mg (sc)
☐ 90 mg (sc)
☐ Other _____

Frequency
☐ Week 0, 4, then every 12 weeks
☐ Every 12 weeks
☐ Other _____

Medication route
N/A
☐ 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 test

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 _____