SPRINGSIDE INFUSION

Simponi Aria

Patient information

Patient name ________________________________ **DOB** ________________________

Mobile number ________________________________ **Weight** ____________ ☐ kgs ☐ lbs

Diagnosis
☐ Rheumatoid arthritis
☐ Psoriatic arthritis
☐ Ankylosing spondylitis
☐ Other ____

Allergies ☐ NKDA ☐ ____

Medication instructions

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

Medication order

Dose
☐ 2m/kg
☐ Other ________________________

Frequency
☐ Weeks 0, 4 and then every 8 weeks
☐ Every 8 weeks
☐ 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 | Negative Hep B

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 ____________________

© Springside Infusion, Inc.