

**Patient information**

Patient name \_\_\_\_\_

DOB \_\_\_\_\_

Mobile number \_\_\_\_\_

Weight \_\_\_\_\_  kgs  lbsDiagnosis  Generalized pustular psoriasis (I40.1)  
 Other \_\_\_\_\_Allergies  NKDA  \_\_\_\_\_**Medication instructions**Pre-medications  N/A  
 Provider prescribed: \_\_\_\_\_Medication order Dose Frequency  
 900 mg x 1 (may repeat 900 mg dose in one week if persistent place)  X1 initial dose  
 Other \_\_\_\_\_  X1 repeat dose  
 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

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 \_\_\_\_\_