Arthritis & Rheumatology Center, PC
Phone: 770-284-3150 Fax: 770-284-3170
www.arcenterpc.com
Roswell / Alpharetta – Cumming – Johns Creek / Suwanee

Infusion Order Form

Patient Name: ____ Date of Birth: _________________________________

Address: ____

Phone: _________________________________ Email: ____

Gender: Male / Female (Please Circle)

Provider Name:		**Specialty:**	
Practice Name:		**Provider NPI:**	
Address:			
Phone:		**Fax:**	

Diagnosis: ____ ICD 10 Code: ____________________________________

TB Test Date: ____________________ Results: POSITIVE / NEGATIVE (Circle)

PPD Date: _____________________TB Spot Date: ______________________ Hepatitis B&C Date: ___________________

If Positive, has patient been treated? YES / NO (Circle) Date of Treatment: ___________________________________

Drug Name: ____

Dosage & Frequency: ____

Patient's Weight: ____________ Lb / kg Height: ___________inches / cm (Date:_______________)

Previously Failed Medications: ____

We Infuse/Inject following medications at our office:

	Remicade		Stelara		***Injectables***
	Orencia		Entyvio		Cimzia
	Rituxan		Venofer		Prolia
	Actemra		IVIG		Xolair
	Benlysta		Solumedrol/ IV Steroid		Stelara
	Krystexxa		Tysabri		
	Cytoxan		Hydration		
	Simponi Aria		Lemtrada		
	Ocrevus				

*** Please fax completed this form with patient demographic, insurance info, office visit note & any labs done.*

If any labs are not done, then our doctors will order labs.

Provider Signature: ____ Date: ______________________

Fax Completed forms with supporting documents to **Fax: 770-284-3170**
For questions, please call **Phone: 770-284-3150 Ext. 306**