Jean Walter Infusion Center - Infusion Therapy Order

www.JeanWalterInfusion.com
Phone: 443-354-3772 Fax:443-354-3767

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

Allergies : _____ Height & Weight: _____

Referring Provider: _____ NPI/DEA: _____

Specialty: _____

Please ensure all sections are completed. Incomplete forms will not be accepted.

Infusion Medication: MEDICATIONS BELOW ARE INTERVENOUS

○ Actemra	○ Iron (Feraheme)	○ Remicade/Biosimilar	○ Reclast
○ Benlysta	○ Krystexxa	○ Rituxan/Biosimilar	○ Leqembi (10mg/kg
○ Vyvgart	○ Ocrevus	○ Simpori Aria	○ Tepezza
○ Entyvio	○ Saphnelo	○ Tysabri	○ Vyepti
○ Skyrizzi	○ Stelara	○ Solaris	○ Orencia

PICC/ Port Line: Yes or No **Diagnosis W/ ICD 10: _____**

Dosing: _____MG/KG or _____MG

Frequency: _____

Maintenance: _____

Number of Refills: _____

Circle one: Is observation required? yes or no If yes, how long? _____

Please indicate labs required at time of infusion:

_____

Please indicate if any premedication is required: ○ CHECK HERE IF NO PREMEDICATION(S) REQUIRED

○ Acetaminophen: mg	○ Solumedrol: mg
○ Diphenhydramine mg	○ Other:

IF NO PREMEDICATIONS INDICATED or ROUTE NOT NOTED ABOVE, WE WILL USE FDA RECOMMENDATIONS

SCRIPTS ARE ONLY VALID FOR 6 MONTHS

Provider Signature: _____ **Date: _____**