OAOC
INFUSION CENTER

Remicade ® | (Infliximab)

Please fax a copy of the following patient information:

☐ Demographics ☐ Insurance information ☐Current Lab Results ☐H&P ☐ Current Medication

Patient Information

Patient Name:_____ DOB:_____
Allergies:_____ Weight: _____ lbs/kg Height:_____
Diagnosis/ ICD-10:
☐ Crohn's disease, unspecified / K50.9 ☐ Ulcerative colitis, unspecified / K51.9
☐ Psoriatic arthritis(PsA), unspecified / L40.52 ☐ Ankylosing Spondylitis(AS), unspecified / M45.9
☐ Rheumatoid arthritis, unspecified / M06.9
☐ Rheumatoid arthritis without rheumatoid factor / M06.00
☐ Rheumatoid arthritis with rheumatoid factor, unspecified / M05.9
☐ Other (please specify) _____
Additional information:
_____

Provider Information

Printed Provider's Name:
_____
Phone: _____ Fax:_____
Office Address:
_____
Contact Person:_____

Medication Information

Dose:_____ Frequency and Duration: _____
Start Date of Infusion:_____ End Date of Infusion:_____
Other Orders or Special Instructions:
_____

2100 116th AVE NE
Bellevue, WA 98004
Phone: (425) 453-0766
Fax: (425) 451-3560

OVERLAKE
ARTHRITIS, OSTEOPOROSIS & INFUSION CENTER