

PATIENT INFORMATION	
Patient Name: _____	Date: _____
Address: _____	Phone: _____
City, State, Zip: _____	
DOB: _____	Weight: _____ Height: _____
<b>Diabetic (Circle one):</b> Yes / No	
Diagnosis / ICD 10 Code: _____	Allergies: _____
<input type="checkbox"/> INITIATION OF THERAPY	<input type="checkbox"/> CHANGE OF INTERVAL
<input type="checkbox"/> CHANGE OF PROVIDER	
If the patient cannot provide recent PPD results (within 12 months), then perform PPD.	
<b>TUBERCULOSIS SCREENING:</b> <input type="checkbox"/> PPD <b>Date Performed:</b> _____ <b>Date Read:</b> _____	
<input type="checkbox"/> PPD results provided by patient per Dr. _____ <b>Date:</b> _____	
<b>Result:</b> <input type="checkbox"/> <b>Negative</b> → May Initiate Remicade® Therapy	
<input type="checkbox"/> <b>Positive</b> → <input type="checkbox"/> Chest X-Ray performed <b>Date Performed:</b> _____ <input type="checkbox"/> <b>Negative result</b> → May initiate Remicade®	
<input type="checkbox"/> <b>Positive result</b> → TB treatment initiated	
<input type="checkbox"/> RN to teach disease management	
<b>Remicade® - Choose Regimen:</b>	
<input type="checkbox"/> 3 mg/kg _____ mg/NS 0.9% 250 mL IV over 2 hours	<input type="checkbox"/> NS 0.9% 50 mL IVPB to flush Remicade from IV tubing
<input type="checkbox"/> 5 mg/kg _____ mg/NS 0.9% 250 mL IV over 2 hours	<input type="checkbox"/> Concomitant po Methotrexate _____ mg/week
<input type="checkbox"/> 10 mg/kg _____ mg/NS 0.9% 250 mL IV over 2 hours	(Methotrexate RX given to Patient)
<input type="checkbox"/> _____ mg/kg _____ mg/NS 0.9% 250 mL IV over 2 hours	<input type="checkbox"/> Repeat dose in 2 weeks, 6 weeks, and then every 8 weeks
<input type="checkbox"/> Repeat dose in 2 weeks and then every 6 weeks	<input type="checkbox"/> Other frequency: _____
<b>Duration of Therapy:</b> <input type="checkbox"/> x 1 year	
<input type="checkbox"/> Other: _____	
* Start infusion at 10 mL/hr. Double the rate after 15 minutes (as tolerated) for the first hour of infusion. (After first 15 minutes → 20 mL/hr, at 30 minutes → 40 mL/hr, at 45 minutes → 80 mL/hr, at 1 hr → 160 mL/hr). At 90 minutes into the infusion, the rate may be increased for the last time to a maximum rate of 250 mL/hr.	
<b>Pre-Medications:</b>	
<input type="checkbox"/> <b>Diphenhydramine</b> _____ mg, po -or- IV (circle one), prior to start of infusion	
<input type="checkbox"/> <b>Acetaminophen</b> 650 mg po prior to start of infusion	
<input type="checkbox"/> <b>Prednisone</b> _____ mg, po -or- <input type="checkbox"/> Methylprednisolone 40 mg IVP -or- <input type="checkbox"/> Hydrocortisone 100 mg IVP	
<input type="checkbox"/> <b>Other:</b> _____	
<b>* Administer pre-medications 15 to 30 minutes prior to start of infusion *</b>	
<b>IV Access:</b>	
<input type="checkbox"/> Start PIV if no IV access available <input type="checkbox"/> Maintain current central line access	
<b>Catheter Care:</b>	
<input type="checkbox"/> Sodium Chloride 0.9% _____ mL IV before and after each IV access and PRN per protocol	
<input type="checkbox"/> Sodium Chloride 0.9% _____ mL as above <b>AND</b> Heparin 100 Units /mL _____ mL IV flush after second saline flush and PRN	
* Dressing changes weekly and PRN	* Antimicrobial dressing PRN
* May obtain blood from IV access for labs	* May use Cathflo 2 mg/2 mL sterile water IVP 2 mL per lumen; May repeat after 2 hours' x 1
<b>Labs:</b>	
<input type="checkbox"/> CBC q _____ <input type="checkbox"/> CMP q _____ <input type="checkbox"/> CRP q _____ <input type="checkbox"/> ESR q _____ <input type="checkbox"/> LFTs q _____ <input type="checkbox"/> X-ray _____ <input type="checkbox"/> Other _____	
<b>Standard Orders for Side Effects:</b>	
<input type="checkbox"/> <b>Promethazine</b> 25 mg - 1-2 tabs po q 4-6 hrs PRN nausea / vomiting	<input type="checkbox"/> <b>Diphenhydramine</b> 25 mg - 1 to 2 caps po PRN
<input type="checkbox"/> <b>Acetaminophen</b> 325 mg - 2 tabs po q 4-6 hrs PRN HA, myalgia, fever	<input type="checkbox"/> <b>Diphenhydramine</b> 25 mg -or- 50 mg IV x 1 dose PRN
<input type="checkbox"/> <b>Promethazine</b> 25 mg IV/IM x 1 dose PRN nausea / vomiting	<input type="checkbox"/> <b>Other:</b> _____
<b>Monitoring Parameters:</b>	
<input type="checkbox"/> Obtain vital signs and temperature q 15 mins for the 1 <sup>st</sup> hour, then q 30 mins for the remainder of the infusion	
<input type="checkbox"/> Observe patient for 30 mins following the infusion	
<input type="checkbox"/> Instruct patient to report symptoms of chills, fever, headache, sore throat, pain, etc.	
<input type="checkbox"/> Other: _____	
<b>Anaphylactic Reaction (AR):</b>	
<b>Epinephrine</b> (based on patient weight)	
EpiPen® Auto-injector 0.3 mg (1:1000) - Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary	
EpiPen Jr® Auto-injector 0.15mg (1:2000) - Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg); may repeat in 3-5 mins x 1 if necessary	
<b>Diphenhydramine</b> 50mg (1mL) - Give 50 mg slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary	
<b>Hydrocortisone</b> 100mg - Give 100 mg IVP -or- IM if no IV access	
<b>Sodium Chloride</b> 0.9% 500 mL infuse IV at a rate of 30 mL/hr	
<b>Other Orders:</b> _____	

Prescribing Physician: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**PHYSICIAN'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

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