



Phone: 1-888-899-7447
Fax: 1-866-368-9808

CAP
Gastroenterology
Patient Order Form

PATIENT INFORMATION

Patient Name		<input type="checkbox"/> Male <input type="checkbox"/> Female	Allergies <input type="checkbox"/> NKDA	
Date of Birth		SSN#	Weight _____ <input type="checkbox"/> kg <input type="checkbox"/> lb	Date
Address		City	State	Zip
Phone # (Home)	(Work)	Email address (optional)		

INSURANCE INFORMATION (PLEASE ATTACH A PHOTOCOPY OF THE FRONT AND BACK OF ALL INSURANCE CARDS)

Primary Insurance		Medicare ID		
Group #	Policy #	Phone #		
Secondary Insurance	Policy #	Phone #		

PREVIOUS MEDICATIONS

If prescribing Remicade, please indicate which of the following the patient has tried previously:
 Methotrexate Humira Orencia Enbrel Rituxan Remicade Kineret Other _____ None of these

PRIMARY DIAGNOSIS AND DATE OF DIAGNOSIS **SECONDARY DIAGNOSIS**

<input type="checkbox"/> 259.2 Carcinoid Syndrome <input type="checkbox"/> 456 Esophageal varices <input type="checkbox"/> 555 Crohn's Disease <input type="checkbox"/> 556 Ulcerative Colitis <input type="checkbox"/> 787.91 Diarrhea NOS	<input type="checkbox"/> 532 Duodenal ulcer <input type="checkbox"/> 531 Gastric Ulcer <input type="checkbox"/> 530.81 GERD <input type="checkbox"/> 251.5 Zollinger-Ellison <input type="checkbox"/> Other ICD 9 _____	<input type="checkbox"/> 259.2 Carcinoid Syndrome <input type="checkbox"/> 456 Esophageal varices <input type="checkbox"/> 555 Crohn's Disease <input type="checkbox"/> 556 Ulcerative Colitis <input type="checkbox"/> 787.91 Diarrhea NOS	<input type="checkbox"/> 532 Duodenal ulcer <input type="checkbox"/> 531 Gastric Ulcer <input type="checkbox"/> 530.81 GERD <input type="checkbox"/> 251.5 Zollinger-Ellison <input type="checkbox"/> Other ICD 9 _____
Year of Primary Diagnosis:			

PRESCRIPTION INFORMATION

Medication	Dose	Directions/Frequency of Administration	Total # Doses
<input type="checkbox"/> Remicade® (Infliximab)	<input type="checkbox"/> 5 mg/kg <input type="checkbox"/> 10 mg/kg <input type="checkbox"/> _____mg/kg (Please fill in weight section)	<input type="checkbox"/> IV @ 0 weeks (induction) <input type="checkbox"/> IV @ 2 weeks (induction) <input type="checkbox"/> IV @ 6 weeks (induction) <input type="checkbox"/> IV every 8 weeks (maintenance) <input type="checkbox"/> IV every _____ weeks	
<input type="checkbox"/> Ranitidine HCl			
<input type="checkbox"/> Octreotide Acetate			
<input type="checkbox"/> Other:			

DELIVERY INSTRUCTIONS

Order will be shipped to the address provided below. Physician must be registered with CAP at this location and this must be the site of administration.	Administration Date * (date of infusion)
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PHYSICIAN CONTACT INFORMATION & AUTHORIZATION

Physician Name	Office Contact	Institution
Phone	Fax	Specialty
Address	City/State/Zip	
DEA #	UPIN #	
CAP PIN #	NPI #	

Physician's Signature _____ Date _____
 (required to process prescription – stamped signatures are not permissible)

R (7/9/07)

***If this order is needed in less than 48 hours please call 888-899-7447 to place order.**