Rituxan Order
(Rituximab)

INFUSION FOR HEALTH

Ph: 805-719-3700 | Fax: 805-852-2636

Date: ___/___/___ Treatment Location: _____

***Please fax a copy of the following patient information:** ☐ Demographics ☐ Insurance Information ☐ Current Medications ☐ H & P Relevant to Diagnosis ☐ Current Lab Results (incl TB & Hep B)

PATIENT INFORMATION

Patient Name: _____

DOB: ___/___/___

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: ___/___/___

Phone: (___) ___-____ Fax: (___) ___-____

Office Address: _____

Contact Person: _____

TB Test Date: ___/___/___ Result: _____ Hep B Date: ___/___/___ Result: _____

Is patient on any antihypertensive meds that will need to be held 12 hrs prior to infusion? ☐ No ☐ Yes

PRE-MEDICATIONS:

Benadryl:	☐ PO	☒ IV	☒ 25mg	☐ 50mg	☒ Pre-med	☐ PRN
Acetaminophen:	☒ PO		☒ 650mg		☒ Pre-med	☐ PRN
Zyrtec:	☒ PO		☒ 10mg		☐ Pre-med	☐ PRN
Solu-Medrol:		☒ IV	☒ 125mg		☒ Pre-med	☐ PRN
Normal Saline Bolus:		☐ IV	☐ 250 mL	☐ 500 mL		

RITUXAN (RITUXIMAB) IV DOSAGE

Dose: _____ **Frequency:** _____

Start Date of Infusion: ___/___/___