PrREMICADE®* (infliximab)

Post-infusion Feedback Report (For referring physician's review)

1. PATIENT INFORMATION

Last Name of Patient:	First Name of Patient:	Date of Birth: (DD/MM/YYYY)

2. IMMUNOSUPPRESSANTS (IF APPLICABLE)

Dose: ______________________________ (mg, Frequency and Route)

3. INFUSION CONFIRMATION REPORT

TO:
Prescribing Physician:
____
Fax #: ______________________________

FROM:
Contact Person:
____
Fax #: ______________________________
Phone #: ______________________________

4. BIOADVANCE® CLINIC & COORDINATOR INFORMATION

Name of BioAdvance® Clinic:
____
Phone #: ______________________________

BioAdvance® Coordinator Name:
____
Fax #: ______________________________

5. INFUSION INFORMATION

REMICADE® Dose Given:	Date of Infusion:	This Infusion #:	Infusion Frequency:	Approx. Next Infusion Scheduled:
❍__________ mg **EXACT Dose/**__________Weight ❍ lbs ❍ kg) ❍__________ 100 mg vials, **exact # of vials**	__________ DD/MM/YYYY	__________	__________	__________ DD/MM/YYYY

PREMEDICATION	DOSE	ROUTE	PREMEDICATION	DOSE	ROUTE
❍ Diphenhydramine HCl (e.g., Benadryl**)			❍ Hydrocortisone (e.g., Solu-Cortef**)		
❍ Dimenhydrinate (e.g., Gravol**)			❍ Prednisone		
❍ Acetaminophen (e.g., Tylenol**)			❍ Other:		
❍ Desloratadine (Aerius®)			❍ Other:		

6. INFUSION REACTION INFORMATION AND GENERAL COMMENTS

❍ Infusion Reaction (Onset, Treatment, Outcome):

Adverse Event reported to Janssen Inc.?
❍ Yes ❍ Not Applicable

General Comments:

7. PLEASE ASK PATIENT

Last Blood Test Performed:	Last Referring Physician Visit:	Next Referring Physician Visit:
__________ DD/MM/YYYY	__________ DD/MM/YYYY	__________ DD/MM/YYYY
Name of Onsite Medical Backup Physician:	**Name of Infusion Nurse:**	**Infusion Nurse's Signature/Date:**
__________	__________	__________ DD/MM/YYYY

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