OAOC INFUSION CENTER

KIRKLAND SPECIALTY INFUSION CENTER

Infusion Site: ☐ OAOC Infusion Center ☐ Kirkland Specialty Infusions

Stelara ® | (Ustekinumab)

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:
☐ Psoriatic arthritis(PsA), unspecified / L40.52
☐ Psoriasis vulgaris (Plaque psoriasis) / L40.0
☐ Crohn's disease, unspecified / K50.9
☐ Ulcerative colitis, unspecified / K51.9
☐ 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:
_____

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