Ozlem Goker-Alpan MD, LLC

3702 Pender Drive, Suite 170, Fairfax, VA 22030 Phone: 571-529-6805
121 Congressional Lane, Suite 320, Rockville, MD 20852 Fax: 703-991-6592

Please complete and attach signed orders and RX, labs, H&P, Copy of TB test, any pertinent medical records, Insurance Card (copy front and back) and Patient Demographic.

Fax to: (703) 991-6592 or email to: ubeese@ldrtc.org

PATIENT NAME: _____

DOB:____/_____/_____

Phone number : (_____) _____ - _____

INSURANCE:_____ Copy attached : ____

REFERRING PHYSICIAN:_____

Phone: (_____)_____- _____

Fax: (_____)_____- _____

Contact Person: _____

Patient Current

Height: _____inch _____cm

Weight: _____ lbs _____ kgs

Diagnosis: _____

ICD-10 _____

ALLERGIES: _____

_____

MEDICATION:

GammaPlex __ Gamunex-C __ Octagam __

Gammagard S/D __ Gammagard liquid __

Hizentra __ HyQvia __ Cuvitru __

Remicade __ Entyvio __ Stelara __

OTHER _____

DOSAGE: _____ mg/gm

ROUTE: __ IV__ SQ __ IM

PORT: __Y__ N

Other:_____

☐ FREQUENCY:_____

☐ Induction at "WEEK" 0 1 2 3 4 5 6 7 8 9 10

☐ Maintenance Frequency: _____

PRE/POST-MEDICATIONS

☐ Infusion protocol (at Ozlem Goker-Alpan, MD)

☐ None

PRE / POST

☐ Diphenhydramine_____/_____mg

☐ Ranitidine_____/_____mg

☐ Acetaminophen_____/_____mg

☐ Ibuprofen_____/_____mg

☐ Corticosteroids_____/_____mg

☐ Other _____

Laboratory

CBC___ CMP___CRP____ ESR____

TB__ MRSA ___ Other _____

_____

***We will not be performing labs safety monitoring unless order by the referred Physician.**

***If no TB result we will prepare the TB quantiferon blood test and MRSA swab at the intake visit.**

Physician Signed:

Date: