ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

Infliximab Level Order

Requesting gastroenterologist **must** submit a completed form with the Laboratory Requisition

Patient Last Name	Patient First Name	ULI #
Collection Date *(dd-Mon-yyyy)*	Collection time *(24 hr)*	

Clinical indication and drug formulation must be provided to ensure proper therapeutic range and reagents are used.

Anti-infliximab Antibody if infliximab greater than 3.0 μg/mL ☐ No ☐ Yes	
Clinical Indication(s) for Testing ☐ Loss of response ☐ Adverse side effect ☐ Therapeutic drug monitoring - steady state trough ☐ Therapeutic drug monitoring - induction trough ☐ Infant exposed in Utero	**Drug Formulation and Dosing** ☐ Remicade ________ mg/ ________ weeks ☐ Inflectra ________ mg/ ________ weeks ☐ Renflexis ________ mg/ ________ weeks Date of the last infusion *(dd-Mon-yyyy)* ________________ Number of prior infusions ______________________ Patient weight at time of collection __________ kg *(Weight to be provided by infusion clinic at time of collection)*
Gastroenterologist Last Name	Gastroenterologist First Name
Pediatrician Last Name	Pediatrician First Name

Attach completed form to completed laboratory requisition