St. Paul's Hospital
1081 Burrard Street, Vancouver, B.C. V6Z 1Y6
604-682-2344

LABORATORY REQUISITION

INFLIXIMAB & ANTI-INFLIXIMAB ANTIBODY

DATE: ______________________________

Patient Last name ______________ **First name** ______________

PHN: ______________________________

Date of Birth: (dd/mmm/yyyy) ______________________________

Address: ______________________________

City: ______________ Postal code: ______________

Telephone: ______________________________

REQUESTING GASTROENTEROLOGIST:

Printed name: ______________________________ Signature: ______________________________

MSP No: ______________ Address: ______________________________

Copy results to: Physician(s) name and MSP No. ______________________________

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Reason for order	Infliximab dosing information
☐ Primary non-response	Dose: ________ mg every _______ weeks
	Date of last infusion: (dd/mmm/yyyy) ______________
☐ Secondary non-response	Number of prior infusions: ______________
☐ Elevated CRP: ______________	Patient weight at time of collection: ________ kg
☐ Active disease on endoscopy	
☐ Active disease on imaging	**Diagnosis**
☐ Worsening symptoms	☐ Crohn's disease
	☐ Ulcerative colitis
☐ Other	☐ Indeterminate colitis
☐ Adverse side effects	
☐ Therapeutic drug monitoring	**Concomitant therapy**
☐ De-escalation	☐ azaTHIOprine ___________ mg/day
	☐ methotrexate ___________ mg/week
	☐ predniSONE ___________mg/day
	Other: ______________________________

SPECIMEN COLLECTION & SHIPPING

Specimen requirements: 1 Red top tube or 1 SST gel tube

Shipment to SPH Lab: Centrifuge and send **2 x 1 mL** aliquots of serum, frozen

Specimen collection window: Immediately prior to next infusion (preferred), or
Less than 2 weeks prior to the next infusion

Anti-infliximab antibody test: Reflexively performed on specimens with infliximab less than 3 mcg/mL

______________________________ ______________________________ ______________
Phlebotomist Collection Date Time