

Neurology Therapies

Please fax completed referral form to 972-473-7563

PATIENT DEMOGRAPHIC INFORMATION

Patient's name: _____ Date of birth: _____ Phone #: _____

Address: _____ City/State/Zip: _____

Allergies: _____ Weight: _____ Height: _____

DIAGNOSIS & CLINICAL INFORMATION

Diagnosis: (ICD 10 Code Required)

- | | |
|--|--|
| <input type="checkbox"/> Amyotrophic Lateral Sclerosis, G12.21 | <input type="checkbox"/> Multiple Sclerosis, G35 |
| <input type="checkbox"/> Guillain-Barré Syndrome G61.0 | <input type="checkbox"/> Chronic Inflammatory Demyelinating Polyneuropathy, G61.81 |
| <input type="checkbox"/> Multifocal Motor Neuropathy, G61.81 | <input type="checkbox"/> Myasthenia Gravis (G70.00-G70.01), ICD 10 _____ |
| <input type="checkbox"/> Other: _____ | |

Prior Failed Therapy:

Med Failed: _____	Length of Treatment: _____	Reason for D/C: _____
Med Failed: _____	Length of Treatment: _____	Reason for D/C: _____
Med Failed: _____	Length of Treatment: _____	Reason for D/C: _____

Test Results: Please attach copy for all items checked.

- | | |
|---|---|
| <input type="checkbox"/> Negative Hepatitis B virus (HBV) screening | <input type="checkbox"/> Electromyography (EMG) and Nerve conduction velocity (NCV) tests |
| <input type="checkbox"/> Meningococcal vaccination | <input type="checkbox"/> Lumbar puncture test |
| <input type="checkbox"/> Nerve biopsy report | <input type="checkbox"/> anti-GM1 antibodies |
| <input type="checkbox"/> Acetylcholine receptor (AChR) antibodies | <input type="checkbox"/> ALS Functional Rating Scale-revised (ALSFRS-r) |
| <input type="checkbox"/> Pulmonary function test | |
| <input type="checkbox"/> Other: _____ | |

Please include copy of insurance card, most recent H&P or MD note, medication list, and lab results.

THERAPY ORDERED

MEDICATION	DOSE	DIRECTIONS/DURATION
IVIG <input type="checkbox"/> No brand preference <input type="checkbox"/> Brand preferred: _____	<input type="checkbox"/> 0.4gm/kg: _____ mg <input type="checkbox"/> 1gm/kg: _____ mg <input type="checkbox"/> Other: _____ mg	<input type="checkbox"/> INITIAL: Infuse IV daily x _____ days <input type="checkbox"/> MAINTENANCE: Infuse IV every _____ weeks x 1 year <input type="checkbox"/> OTHER: _____
Ocrevus® (ocrelizumab)	INITIAL: 300mg MAINTENANCE: 600mg	<input type="checkbox"/> INITIAL: Infuse 300mg IV at Weeks 0 and 2 <input type="checkbox"/> MAINTENANCE: Infuse 600mg IV every 6 months x 1 year
Soliris® (eculizumab)	INITIAL: 900mg MAINTENANCE: 1200mg	<input type="checkbox"/> INITIAL: Infuse 900mg IV weekly x 4 weeks <input type="checkbox"/> MAINTENANCE: Infuse 1200mg IV every 2 weeks x 1 year
Radicava® (edaravone)	60mg	<input type="checkbox"/> INITIAL: Infuse IV daily x 14 days, followed by 14 days drug free <input type="checkbox"/> MAINTENANCE: Infuse IV daily x 10 days in a 14-day period, followed by 14 days drug free x 1 year
OTHER:		
OTHER:		

Is patient currently receiving therapy above from another facility? NO YES If yes, Facility Name: _____

REFERRING PHYSICIAN INFORMATION

Physician Name: _____ Specialty: _____

Address: _____ City/State/Zip: _____

Office Contact: _____ Phone #: _____ Fax #: _____