NORTHEAST REGIONAL
Infusion Services
AT
Richardson
MEDICAL CENTER
PHONE: (318) 728-8237 FAX: (877) 249-1191

☐ **STAT REFERRAL**

NEUROLOGY ORDER FORM

PATIENT INFORMATION

Last Name: ______________________________ First Name: ______________________________ MI____ DOB:____________

HT: _________ in WT: ________ ☐ lbs ☐ kg Sex: ☐ Male ☐ Female Allergies: ☐ NKDA, ______________________________

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Physician Name______________________________ Contact Name ____________________ Contact Phone # ____________________

NPI #:______________________________ Tax ID#:______________________________ Fax #: ______________________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: ICD 10 + Description:______________________________ Date of Diagnosis:_______________

PERTINENT MEDICAL HISTORY

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**______________________

PRESCRIPTION ORDERS:

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY
b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED FOLLOWING HOSPITAL POLICY
c) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE

SELECT	MEDICATION / DOSE	ROUTE	FREQUENCY	DURATION
☐	TYSABRI 300 mg **PATIENT WILL BE OBSERVED FOR 1 HOUR POST INFUSION*	IV		12 MONTHS
☐	OCREVUS LOADING DOSES	IV	300 mg at 0, 2 weeks, then 600mg once every 6 months	
☐	OCREVUS 600 mg MAINTENANCE DOSES	IV	Once every 6 months	
☐	SOLU-MEDROL _________mg	IV		

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE
☐	BENADRYL		
☐	ACETAMINOPHEN		
☐	SOLUMEDROL		
☐	OXYGEN		
☐	FAMOTIDINE		
☐	Other:		
☐	Other:		

LABS

SELECT	LAB REQUESTED	WHEN	FREQUENCY
☐	BMP	☐ PRIOR ☐ POST	
☐	CMP	☐ PRIOR ☐ POST	
☐	BUN/CREATININE	☐ PRIOR ☐ POST	
☐	JCV ANTIBODY (Patients taking Tysabri)	☐ PRIOR ☐ POST	EVERY 6 MONTHS
☐	CRP	☐ PRIOR ☐ POST	
☐	ESR	☐ PRIOR ☐ POST	
☐	Other:		

NOTES/INSTRUCTIONS/COMMENTS:

Physician's Signature ______________________________**Time**____________________ **Date**______________
**Signature Must Be Clear and Legible*

Cosignature (If Required)______________________________ **Time**____________________ **Date**______________
**Signature Must Be Clear and Legible*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.