SHERIDAN COMMUNITY HOSPITAL
OUTPATIENT INFUSION CENTER
PHONE: 989.291.6295 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, _____

_____

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.