Seminole Hospital District
INFUSION CENTER
Phone: 432-758-4716 Fax: 877-249-1191

☐ **STAT REFERRAL**

NEUROLOGY ORDER FORM

PATIENT INFORMATION

Last Name: ______________________________ First Name: ______________________________ MI_______ DOB:_______________

HT: _________ in WT: ________ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):______________________________

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Provider 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 PER HOSPITAL PROTOCOL PRN UNLESS OTHERWISE NOTED BY PROVIDER

b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED PER STANDARD PHARMACY CONCENTRATIONS AND HOSPITAL POLICY

c) PATIENTS TAKING OCREVUS: Hep-B antigen surface antibody test? ○ Yes ○ No Date: ___________________

SELECT	MEDICATION / DOSE	ROUTE	FREQUENCY	DURATION
	TYSABRI 300 mg **Infuse Over 1 Hour** ***PATIENT WILL BE OBSERVED FOR 1 HOUR POST INFUSION***	**IV**	**Every 4 Weeks**	**12 MONTHS**
	OCREVUS LOADING DOSES **Infuse over at least 2.5 Hours** **Requires 0.2 or 0.22 Micron In-Line Filter**	**IV**	**300 mg at 0, 2 weeks, then 600mg once every 6 months**	
	OCREVUS 600 mg MAINTENANCE DOSES **Infuse or at least 2.5 Hours** **Requires 0.2 or 0.22 Micron In-Line Filter**	**IV**	**Once every 6 months**	
	SOLU-MEDROL mg	**IV**		

PREMEDS

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

LABS

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

NOTES/INSTRUCTIONS/COMMENTS/SPECIFIC BRAND OR TITRATION ORDERS:

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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.