Southwestern Medical Center
Empowered by ScionHealth
Phone: 580-531-4892
Fax: 877-249-1191

☐ **STAT REFERRAL**

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES

NEUROLOGY ORDER FORM

PATIENT INFORMATION

Last Name: ____________________ First Name: ____________________ MI_______ DOB:_______________

HT: _________ in WT: ________ 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 PROTOCOL

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

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 MAINTANENCE 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)	(X) PRIOR ( ) POST	EVERY 6 MONTHS
	CRP	( ) PRIOR ( ) POST	
	ESR	( ) PRIOR ( ) POST	
	Other:		

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

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.