vitalcare INFUSION SERVICES of GREENVILLE

Pharmacy Name: VITAL CARE OF GREENVILLE
Address: 274 COMMONWEALTH DR, STE C
City/State/Zip: GREENVILLE, SC 29615
Phone: 864-438-2800
Fax: 864-438-2801
Email: SNMULLINS@VITALCARE.COM

NEUROLOGY REFERRAL FORM

Patient Name	Home Phone		
Date of Birth	Mobile or Work Phone		
Patient Address	City	State	Zip
Primary/Secondary Insurance Name			
Insured Name	Insured DOB		

SEND COPY OF INSURANCE CARD AND MEDICAL HISTORY WITH REFERRAL

Ordering Physician Name	NPI		
Physician Address	City	State	Zip
Phone	Fax		

Please fax the following information: ☐ History and Physical ☐ Pertinent Lab Work ☐ Front & Back copy(s) of patient's insurance card(s)

Prescription

☐ **Intravenous Immunoglobulin**

☐ 0.4 gm/kg ☐ 1 gm/kg ☐ 2 gm/kg ☐ _____ grams

Infuse: ☐ IV daily x ____ day(s); repeat every ____ week(s) x ____ cycles

☐ OTHER _____

☐ **Subcutaneous Immunoglobulin**

Infuse _____ grams OR _____ mls using _____ sites

_____ time(s) per week for _____ months.

Hydration order: _____ mls NSiv to be infused prior/post IVIG.

☐ Pre-medications: Acetaminophen 650mg PO 30 mins prior to infusion
Diphenhydramine 25mg PO 30 mins prior to infusion

☐ Other Pre-medications: _____

Clinical Information

Patient Weight	Height	Allergies

☐ IV access [for IVIGg patients only]: _____ ☐ Nurse to place PIV prior to therapy

Diagnosis	ICD-10
NEUROMUSCULAR	
☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	G61.81
☐ Guillain-Barre Syndrome (GBS)	G61.0
☐ Multifocal Motor Neuropathy	G61.82
☐ Myasthenia Gravis (MG)	G70.0
☐ Myasthenia Gravis with (Acute) Exacerbation	G70.01
☐ Autoimmune Encephalopathy	G04.81
☐ Inflammatory Neuropathies	G61.89
☐ Relapsing Remitting Multiple Sclerosis (RRMS)	G35
☐ Stiff Person Syndrome	G25.82

Diagnosis	ICD-10
OTHER	
☐ Idiopathic Thrombocytopenic Purpura	D69.3
☐ Dermatopolymyositis	M33.90
☐ Polymyositis	M33.20

Please Draw:

☐ CBC/diff ☐ CMP ☐ IgG w/ subclasses 1-4 ☐ Quant. Ig

☐ _____ ☐ _____ Frequency: _____

Anaphylaxis Protocol:

☐ **PER Pharmacy Protocol**

☐ **PER Prescriber Protocol:** _____

Notes:

Flushing Protocol:

○ **PER Pharmacy Protocol**

○ **PER Prescriber Protocol:** _____

I authorize Vital Care Infusion Services LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

Physician Signature: _____

Date: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED