

Pharmacy Name:  
Address:  
City/State/Zip:

Phone:  
**Fax:**  
Email:

**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	
<b>SEND COPY OF INSURANCE CARD AND MEDICAL HISTORY WITH REFERRAL</b>			
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**

<p><b>Intravenous Immunoglobulin</b></p> <p>0.4 gm/kg    1 gm/kg    2 gm/kg    _____ grams</p> <p>Infuse:    IV daily x ____ day(s); repeat every ____ week(s) x ____ cycles</p> <p><b>OTHER</b> _____</p>	<p><b>Subcutaneous Immunoglobulin</b></p> <p>Infuse _____ grams OR _____ mls using _____ sites</p> <p>_____ time(s) per week for _____ months.</p>
<p>Hydration order: _____ mls NSiv to be infused prior/post IVIG.</p> <p>Pre-medications: Acetaminophen 650mg PO 30 mins prior to infusion    Other Pre-medications: _____</p> <p>Diphenhydramine 25mg PO 30 mins prior to infusion</p>	

**Clinical Information**

Patient Weight	Height	Allergies	
IV access [for IVIG patients only]: _____		Nurse to place PIV prior to therapy	
<b>Diagnosis</b>	<b>ICD-10</b>	<b>Diagnosis</b>	<b>ICD-10</b>
<b>NEUROMUSCULAR</b>		<b>OTHER</b>	
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	G61.81	Idiopathic Thrombocytopenic Purpura	D69.3
Guillain-Barre Syndrome (GBS)	G61.0	Dermatopolymyositis	M33.90
Multifocal Motor Neuropathy	G61.82	Polymyositis	M33.20
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		
<b>Please Draw:</b>		<b>Anaphylaxis Protocol:</b>	
CBC/diff    CMP    IgG w/ subclasses 1-4    Quant. Ig		<b>PER Pharmacy Protocol</b>	
_____    _____    _____    _____		<b>PER Prescriber Protocol:</b> _____	
		Frequency: _____	

<p><b>Notes:</b></p>	<p><b>Flushing Protocol:</b></p>
	<p><b>PER Pharmacy Protocol</b></p>
	<p><b>PER Prescriber Protocol:</b> _____</p>

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**

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This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations.