

**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 MEDIPOINTS / IV ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY  
 b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED FOLLOWING HOSPITAL POLICY

SELECT	MEDICATION / DOSE	ROUTE	FREQUENCY	DURATION
<input type="checkbox"/>	TYSABRI 300 mg *PATIENT WILL BE OBSERVED FOR 1 HOUR POST INFUSION	IV		12 MONTHS
<input type="checkbox"/>	OCREVUS LOADING DOSES	IV	300 mg at 0, 2 weeks, then 600mg once every 6 months	
<input type="checkbox"/>	OCREVUS 600 mg MAINTENANCE DOSES	IV	Once every 6 months	
<input type="checkbox"/>	SOLU-MEDROL _____mg	IV		

**PREMEDS**

SELECT	MEDICATION	DOSE	ROUTE
<input type="checkbox"/>	BENADRYL		
<input type="checkbox"/>	ACETAMINOPHEN		
<input type="checkbox"/>	SOLUMEDROL		
<input type="checkbox"/>	OXYGEN		
<input type="checkbox"/>	FAMOTIDINE		
<input type="checkbox"/>	Other:		
<input type="checkbox"/>	Other:		

**LABS**

SELECT	LAB REQUESTED	WHEN	FREQUENCY
<input type="checkbox"/>	BMP	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	CMP	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	BUN/CREATININE	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	JCV ANTIBODY (Patients taking Tysabri)	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	EVERY 6 MONTHS
<input type="checkbox"/>	CRP	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	ESR	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST	
<input type="checkbox"/>	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